Child Fatality Report

Report Identification Number: NY-19-126

Prepared by: New York City Regional Office

Issue Date: May 19, 2020

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: 14 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 11/23/2019
Initial Date OCFS Notified: 11/25/2019

Presenting Information

Per the Preventive Services (PPRS) agency notification to OCFS, on November 23, 2019 at approximately 9:00 PM the subject child (SC) was allegedly train-surfing according to the news media. The body was found on the Queensboro Plaza # 7 train tracks. The BM called the PPRS Case Planner (CP) on November 25, 2019 at 10:05 AM, to inform the CP and agency of her son's death.

Executive Summary

According to information documented in the case record and news media reports, the subject child (SC) was train surfing on 11/23/19 and died after either striking his head on an object and falling from the elevated train or fell off the elevated train. There was no SCR report in response or related to the child's death; therefore, no CPS investigation was conducted.

The New York City, Office of the Chief Medical Examiner conducted an autopsy of the SC on November 24, 2019. The cause of death was, "multiple injuries to head, torso, and extremities"; The manner of death was, "accident as the result of riding on top of the train." OCFS received the Report of Autopsy on February 11, 2020. Per SSL 20(5), OCFS formally requested the SC's Certificate of Death from the NYC DOHMH, Office Vital Records on 12/2/2019 via mail. It was not received at date of this report.

The PPRS agency was notified of the SC's death on 11/25/19 by the BM via telephone. On the same date the CP, supervisor, and program director visited the home; they offered condolences and bereavement services. On 12/6/19, the CP and supervisor attended the SC's wake. The agency provided a check in the amount of $1,000.00 directly to the funeral home to help defray the family's costs.

The PPRS case began 4/30/19 following a report to the SCR that the SC was not attending school or receiving needed mental health services; that the BM was aware and had not taken any steps to address those issues. During CPS' investigation, the family was referred for PPRS with Rising Ground/Edwin Gould, General Preventive (GP) program. The CP and CPS met with the family on 5/15/19 for a joint home visit during which the BM signed for services.

Throughout the services case, the agency adhered to casework contact standards, maintained in-person and telephone collateral contacts that included the SC's school and therapist. Per case documentation, CPS and the CP conducted a home visit on 8/1/19 during which the BM agreed to take the SC to a community clinic the next day for an evaluation. On 8/8/19 the CP contacted the BM who informed the child was not seen as they got to the clinic late. On same date, the CP contacted a community-based provider to refer the SC for MH services and evaluation; there was no available appointment until after 8/23/19. On 8/26/19, the CP contacted the provider to schedule an appointment for the SC; however, the earliest intake date at the agreed upon provider was 9/5/19. Therefore, the CP urged BM to take other steps including taking the child to the emergency room for an evaluation. The SC began therapy on 9/5/19. Per case documentation, the SC was attending his therapy sessions. However, there was no documented assessment in the case record regarding what impact the therapy had on the SC's behavior.

Following the SC's death, the agency offered bereavement services to the BM that were refused. Given that there were no minor children residing in the home, the PPRS submitted the services case for closure in CONNECTIONS on 1/15/20; it was closed 1/21/20.

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?** N/A

Determination:

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

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:
The BM notified the CP of the SC's death on 11/25/19. The CP, supervisor, and program director visited the home the same day to offer condolences and offered bereavement counseling. Collateral contacts occurred with the SC's school, probation officer and therapist to inform them of the fatality. The agency paid $1,000 to the funeral home. The BM also resumed individual therapy.

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: 11/23/2019 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Queens
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? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown

☒ Other: Train Surfing

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	Adult Sibling	No Role	Male	22 Year(s)
Deceased Child's Household	Adult Sibling	No Role	Male	21 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	14 Year(s)
Deceased Child's Household	Mother	No Role	Female	41 Year(s)

LDSS Response

On 11/25/19 at 10:05am, the BM contacted the PPRS agency and informed the CP of the SC's death. Per news media reports and the BM, the SC was train surfing on the 7-train line. He was either struck by something while atop the train or lost his grip and fell from the elevated train. His body was found on the tracks at the Queensboro Plaza station. Per the BM, the SC had permission to hang out with friends and had checked in with her via telephone approximately one hour before his death.

The SC's death was not reported to the SCR as a fatality; therefore, no CPS investigation was initiated in response to his death.

At the time of the SC's death, he was engaged in therapy for several weeks with a community provider; an appointment with a psychiatrist for a medication evaluation was pending.

The CP, supervisor, and program director visited the BM's home 11/25/19 to offer condolences, support, and bereavement counseling. The CP notified the SC's school, probation officer, and therapist of his death, and sought financial assistance for the family. The school established a fund to provide assistance to the family, and the therapist reached out to the BM. Reportedly, the forms involved were too daunting to complete so the BM declined. The CP and supervisor attended the child's wake on 12/6/19 and provided $1,000.00 directly to the funeral home to help reduce the financial burden on the family.

The SC's two adult surviving siblings (SS's) resided in the home. Apart from the SC, no other minor children resided in the home. Therefore, after the SC's death the family was no longer eligible for PPRS and, the case was closed on 1/21/20.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Not applicable. There is no OCFS approved Child Fatality Review Team (CFRT) in NYC.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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:
The SC had two older siblings who resided in the home; both surviving siblings are adults. No children under the age of 18 lived in the home following the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement counseling was offered to the BM which she declined. The agency paid $1,000 directly to the funeral home to defray costs to the family.

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? No

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)

07/29/2019	Deceased Child, Male, 14 Years	Mother, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 14 Years	Mother, Female, 41 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The 7/29/19 SCR report alleged LMC and IG of the SC by the BM. Per the narrative, the SC was diagnosed with a mental health condition; it was recommended that he receive medication to assist with his impulsive behaviors. The BM failed to follow up with the SC's needed mental health treatment even though the BM was aware he was a potential danger to himself and others. The SC was acting out, breaking items, and was becoming physical with others. The school had spoken with the BM about the concerns; the BM did not follow-up with school staff or answer the phone.

Report Determination: Unfounded | **Date of Determination:** 09/18/2019

Basis for Determination:
The allegations of IG and LMC were determined to be UNF. During the investigation CPS learned that the BM had been making efforts to get the SC to school. The BM met with school staff and developed a "behavioral plan". In addition, the BM in conjunction with the PPRS CP, scheduled an intake appointment with a mental health provider but due to a backlog the earliest date given was 09/05/19. The BM explored other providers and could not get an Intake date earlier than 09/04/19.

OCFS Review Results:
CPS conducted a thorough investigation and the determination was appropriate given the circumstances.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/06/2019	Deceased Child, Male, 14 Years	Mother, Female, 41 Years	Educational Neglect	Substantiated	No
	Deceased Child, Male, 14 Years	Mother, Female, 41 Years	Lack of Medical Care	Substantiated	

Report Summary:
The 3/6/19 SCR report alleged LMC and EdN of the SC by the BM. Per the narrative, the SC was absent from school 33 days, and was late 65 days of the school year (2018-2019). As a result, he was failing academically. The BM was aware, however did not adequately address the matter. The SC was highly impulsive, easily distracted, and wandered around when he did attend school. The BM failed to comply with a recommended mental health evaluation of the SC.

Report Determination: Indicated | **Date of Determination:** 05/01/2019

Basis for Determination:
CPS determined that the allegations of LMC and EdN were Sub. The school expressed concerns about the SC's behaviors and met with the BM to discuss having him evaluated. The BM agreed to have the SC evaluated and he was referred for services. At time of the investigation conclusion, the BM did not follow through with completing intake for services.
Also, since the initiation of CPS' investigation, the SC was absent from school 7 times and late 18 times. The BM made no efforts to ensure he attended school daily and on time. The SC continued to display out of control behaviors in school and while traveling on his own. The case remained open for services.

OCFS Review Results:
CPS conducted a thorough investigation. The report source, maltreated SC, subject, and other family members were interviewed. CPS made contact with collaterals that included the SC's medical provider and school staff. Efforts were made to involve the family in addressing child welfare concerns, and the decision to refer to preventive services was made with the family.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

The BM had 4 children, 3 were adults; 1 of whom did not reside at the case address or included in the case family composition at time of the fatality. The family has extensive CPS history that was investigated by ACS as follows:

The BM and BF were subjects in 2 reports between February 1996 to January 1997 that were IND. Allegations were IG of 1 adult SS.

The BM and BF were subjects in 5 reports from September 2008 to April 2013; 4 were IND and 1 was UNF. The BM was the subject in 4 reports from August 2013 to May 2014; 2 were IND and 2 were UNF. The allegations were combinations of IG, LS, PD/AM, CD/A, IF/C/S, S/D/S, L/B/W, and EdN of the 3 adult SS's by the BM and/or BF.

There was 1 report in December 2009 that was IND. It alleged PD/AM, IG, and IF/C/S of the 3 adult SS's by the BF; the BM had no role.

Between January 2015 through June 2016, the BM was a subject in 2 reports that were IND; the BM and BF were subjects in 1 report that was IND; and the BM and 1 adult SS were subjects in 2 reports that were UNF. Allegations were combinations of IG, LS, PD/AM, IF/C/S, and EdN of the SC and the 2 adult SS's who lived in the home.

Known CPS History Outside of NYS

The family has no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 04/30/2019

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 04/30/2019

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☐	☐	☒	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine

Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? Per CONNECTIONS, the Reassessment FASP due date was 11/27/19; it was approved on 11/29/19.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Preventive services were provided by Rising Ground/Edwin Gould, a voluntary agency contracted by the LDSS/ACS to provide child welfare services to families.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☒Yes ☐No

Issue:	Eligibility for Preventive Services
Summary:	The SC was the only minor residing in the home. After his death on 11/23/19, the family was no longer eligible for PPRS. The agency should have completed a Plan Amendment and submit the case for timely closure. The case was not closed until 1/21/20.
Legal Reference:	18 NYCRR 423.3 and 430.9
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies regarding eligibility for PPRS and case closure. ACS must ensure that Rising Ground/Edwin Gould meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed and the action plan.

Preventive Services History

During the investigation of an 3/6/19 SCR report, CPS determined that the family would benefit from PPRS to address the SC's truancy and 'maladaptive' behaviors in the community. The services referral was made 4/1/19; a joint home visit by CPS and the PPRS CP occurred on 5/15/19.

During the services period, the BM was available for casework contacts, was cooperative and engaged. However, the BM did not follow through on agreed upon goals that included a mental health evaluation of the SC and reengaging in her individual mental health counseling. During casework contacts, the CP consistently held age-appropriate conversations with the SC.

Per case documentation, the SC was arrested prior to the opening of the PPRS case; other arrests occurred during the services period. The CP maintained contact with the SC's probation officers and school personnel. The CP provided casework counseling and support to the family. The BF did not reside in the home but visited; and reportedly had a positive relationship with the child. 2 adult siblings (SS's) lived in the home; however, the CP did not speak to them or explore whether they could be supportive resources for the SC.

At time of the SC's death no other minor children resided in the home; the PPRS case was closed 1/21/20.

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