Child Fatality Report

Report Identification Number: NY-22-063

Prepared by: New York State Office of Children & Family Services

Issue Date: Jan 20, 2023

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	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
Age: 12 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 08/12/2022
Initial Date OCFS Notified: 08/12/2022

Presenting Information

The Administration for Children's Services (ACS) completed an OCFS-7065 Agency Reporting Form on 8/12/22, after learning of the 12-year-old male subject child's death. The form reported on 8/11/22, sometime before 9:43PM, while in the care of the mother and stepfather, the child appeared to have hanged himself from the shower rod in the bathroom of the home. The stepfather found the subject child and the family called 911. EMS responded, found a slight pulse, and administered medication to increase blood to the brain. The child was taken to the hospital, transferred to a pediatric intensive care unit, and pronounced dead on 8/12/22 at 5:55AM.

Executive Summary

This fatality report concerns the death of the 12-year-old male subject child that occurred on 8/12/22. ACS was made aware that the subject child died from hanging himself in the family's bathroom. The fatality occurred during an open investigation, which was received at the time of the fatal incident on 8/11/22. At the time of the subject child's death, he resided with his mother, stepfather, and 7-year-old sibling.

On 8/11/22, around 9:00PM, the subject child went into the family's bathroom to shower. A short time later, his 7-year-old sibling knocked on the door and received no answer. The sibling alerted the mother, who was in her bedroom. The mother got up and opened the unlocked bathroom door while the sibling returned to her bedroom. The mother called the subject child's name and received no response, so she opened the shower curtain and saw him hanging by his neck by the removeable shower head. The mother attempted to remove him; however, was unable to free him and called to the stepfather for assistance. The stepfather was able to remove the child from the shower head and laid him in the tub. The mother initiated CPR and the child vomited. The stepfather called 911. Upon arrival, paramedics took over lifesaving efforts and the child was transported to the hospital via ambulance. The child was in cardiac arrest, had no pulse or heartbeat, and efforts were made to increase blood flow to the brain. The child was transferred to a second hospital with an intensive care unit. Attempts to increase blood flow to the brain were unsuccessful and the child was pronounced dead at 5:55AM on 8/12/22.

The medical examiner was notified of the death by hospital staff and an autopsy was scheduled for the following day. The medical examiner reported bruising around the child's neck with no other injuries found. Toxicology reports showed no substances other than fentanyl, which was administered by the hospital. The autopsy report was not requested by ACS.

ACS made several home visits and interviewed the mother, stepfather, sibling, and extended family; the child's biological father died in 2021. The sibling was assessed to be safe and remained in her parents' care. The family was offered bereavement services and were engaged in counseling services when the case closed.

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:
ACS gathered information around the fatal incident and offered relevant services to the family, which they accepted. The sibling's safety was assessed and the family was engaged in counseling services, which they reported finding beneficial. No additional service needs were identified and the case was closed.

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: 08/12/2022 **Time of Death:** 05:55 AM

Date of fatal incident, if different than date of death: 08/11/2022
Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 09:32 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: in the bathroom

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	No Role	Male	12 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	37 Year(s)

LDSS Response

ACS interviewed BM about the events leading up to SC's death. SC arrived home from summer school on 8/11/22 at 5:45PM. After picking up a new pair of glasses, SC went to the park on his own and returned home at 7:30PM, at which point SC and SS began watching TV. BM noted nothing out of the ordinary. The family ate dinner around 8:30PM and SC was sent to shower around 9:00PM. A short time elapsed and the parents sent SS to brush her teeth. SS knocked on the bathroom door and told her parents there was no response. BM got up and opened the bathroom door and noticed the shower curtain was not where it usually was. BM called SC's name and got no response. BM opened the shower curtain and saw SC hanging by his neck, with his legs still touching the floor, but his body was bent and leaning. BM could not get SC down and called the stepfather (PS) for help. PS got SC down, laid SC in the tub, and called 911 at 9:32PM while BM called a relative to get SS. BM said she pushed on SC's chest and vomit came out of his mouth and nose. EMS arrived and took over CPR. BM rode in the ambulance with SC. ACS interviewed PS separately and PS's account of the events was consistent with BM. It was learned during the investigation that a girl had recently broken up with SC and that his father passed away in 2021.

ACS interviewed SS who reported SC was in the bathroom because he was taking a shower. SS believed SC fainted in the shower because he had asthma; however, had not seen SC faint, as no one was in the bathroom with SC at the time. SS was assessed safe in her parents' care.

ACS spoke with numerous relatives, none of whom had anything concerning to report to ACS. Neither the parents nor family members reported MH concerns for SC.

ACS spoke with hospital staff and learned on 8/11/22, SC was brought to the emergency room at 10:14PM via EMS and was in respiratory and cardiac arrest. SC had no pulse or heartbeat, and medication was administered during transport to increase blood flow to the brain. EMS was able to obtain a slight pulse, although no blood flow to the brain. SC required more intensive care and was transported to a hospital with an intensive care unit at 3:52AM. Medication was administered again to increase blood flow to the brain and was unsuccessful. SC was pronounced dead at 5:55AM on 8/12/22. SC was observed with strangulation marks around his neck and no other visible marks or bruises.

ACS learned from the ME that the death scene was observed, and vomit was found on the floor, which was consistent with the family's report. Additionally, the shower was assessed, and no defects were found. At the time of the conversation with the ME, the autopsy had not yet been performed.

ACS contacted numerous collaterals, including LE, ME, hospital staff, relatives, school staff, and the pediatrician. School staff, who also provided summer camp to SC, reported no concerns regarding SC's behavior or the parents' caretaking. The pediatrician reported no concerns and noted SC's depression screen was normal.

ACS offered PPRS services to the family in response to the fatality. The family was originally receptive; however, while

waiting for an agency to be identified, the family secured their own counseling services within the community and declined further services. The family services stage was closed.

Official Manner and Cause of Death

Official Manner: Suicide
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 referred to an OCFS approved Child Fatality Review Team? No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS interviewed numerous family members and collaterals; however, the ME was contacted prior to the autopsy being performed, and there was no additional outreaches to EMS following an unsuccessful attempt.

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?	☐	☐	☒	☐
Explain: Although a 24 hour safety assessment was not required because this was not an SCR reported fatality, ACS assessed the sibling's safety within 24 hours of the fatality and she was assessed safe.				

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?	☐	☒	☐	☐
Explain as necessary: The surviving sibling's safety was assessed within 24 hours, she was assessed safe and remained in her parents' care. The sibling was engaged in counseling services prior to the closing of the case. The family reported the counseling services they were receiving were helpful.				

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? Yes
Explain:
The surviving sibling was engaged in counseling services through a community based provider prior to the case closing.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were engaged in counseling services through a community based provider prior to the case closing. The family was originally receptive to PPRS; however, due to a provider not yet being identified and the family already engaged in counseling with providers they felt comfortable with, the family declined PPRS.

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?	No
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)
08/12/2022	Deceased Child, Male, 12 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 12 Years	Stepfather, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged that on 8/11/22, sometime prior to 9:43PM, while in the mother and stepfather's care, the subject child attempted to end his life by hanging himself with the shower curtain on the shower rod. As a result, the subject child was in critical condition. Subsequently, there were prior concerns pertaining to child abuse in the home. As a result, the mother and stepfather were made alleged subjects. The 7-year-old sibling had an unknown role.

Report Determination: Unfounded **Date of Determination:** 10/07/2022

Basis for Determination:
The allegation of Inadequate Guardianship was unfounded against the mother and stepfather regarding the subject child, as both parents responded appropriately to the subject child hanging himself in the bathroom. The mother attempted to remove the shower head from around the child's neck immediately upon finding him and called to the stepfather for assistance. The stepfather removed the showerhead and the mother called 911 and medical treatment was immediately sought.

OCFS Review Results:
ACS initiated their investigation within 24 hours, contacted the source of the report, interviewed the family and extended family, as well as relevant collateral sources. ACS learned there were no prior concerns pertaining to child abuse in the home. The family was originally receptive to PPRS; however, by the close of the investigation were no longer interested as they had secured their own counseling services. The case was unfounded and closed.

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

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

In 2012, a court ordered investigation (COI) was ordered by Kings County (Brooklyn) Family Court. The SC's mother was seeking custody of the child due to domestic violence perpetrated against the mother by the now deceased biological father. Allegations of Inadequate Guardianship were substantiated against the biological father regarding the SC. The mother was granted an order of protection against the biological father and the family was referred to community-based services. The COI was submitted to family court, and the case was closed.

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? 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