Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-068

Prepared by: New York City Regional Office

Issue Date: Jan 24, 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: Female
Date of Death: 05/14/2022
Initial Date OCFS Notified: 08/31/2022

Presenting Information

An SCR report alleged that on 5/14/22, the mother woke up and saw that the 12-year-old subject child had fallen out of bed facedown and was purple. The mother did not call EMS for 45 minutes despite knowing the child had medical conditions. When EMS arrived at the home the child was pronounced dead. In addition, the SCR report alleged that there was a history of the mother and father hitting the child and the child was hospitalized for injuries related to being hit. Despite the child's disabilities, the mother would push the child past her limits and not let her rest. There was a history of the father perpetrating violence against the mother. The report additionally alleged that in the winter of 2022, the mother kicked the twin sibling out of the house without adequate clothing. In July 2022, the mother and twin got into a physical altercation. In August 2022, the mother left the country and did not make an adequate plan for the twin sibling's care.

Executive Summary

On 8/31/22, the Administration of Children's Services (ACS) received an SCR report regarding the death of the 12-year-old female child that occurred on 5/14/22. The report alleged DOA/Fatality and Lack of Medical Care against the mother regarding the subject child and Inadequate Guardianship against the mother and father regarding the child and sibling. At the time of the death, the child resided with her mother and twin sibling. The father resided outside of the home. Upon receipt of the SCR report, ACS assessed the safety of the twin sibling and determined there were no concerns.

Throughout the investigation, it was learned that the subject child had several medical diagnoses, including altered mental status, failure to thrive in child, hip dysplasia, chromosome disorder, seizure disorder, and neuroblastoma. The medical records received from the hospital indicated the child saw a neurologist and received services for physical therapy, occupation therapy, and speech therapy.

ACS obtained information from the medical examiner's office. After the medical examiner's office spoke with doctors and health care officials, it was determined that an autopsy would not be completed. The child's case was closed as it was determined that there was no suspicion of abuse or maltreatment of the child, and that the child's passing was due to underlying medical conditions. The child's cause of death was documented as complications of neuroblastoma.

ACS spoke with law enforcement and learned the criminal investigation was closed as no criminality was detected regarding the death. ACS spoke with the district attorney's office and was informed their case was closed on 9/2/22, as there was no suspicion of child abuse and the child had underlying medical issues.

Due to the information gathered from medical collaterals and the family, ACS determined there was not a fair preponderance of evidence to substantiate the allegations of DOA/Fatality, Inadequate Guardianship and Lack of Medical Care.

ACS initiated an early childhood consult and adolescent mental health consult for the family. The sibling and parents were enrolled in mental health counseling prior to the CPS investigation, and it was recommended the family continue with their mental health counseling. ACS offered additional bereavement services which were declined by the parents. The family was provided with information on community-based services and the investigation was unfounded and closed on 10/28/22.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
The safety of the twin sibling was regularly assessed throughout the investigation. ACS made an appropriate determination given the information gathered.

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 documented regular supervisory consultations throughout the investigation. Casework activity was commensurate with case circumstances.

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: 05/14/2022 **Time of Death:** 09:52 AM

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: 07:39 AM
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

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	Female	12 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	54 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	12 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	51 Year(s)

LDSS Response

Upon receipt of the SCR report on 8/31/22, ACS initiated their investigation, coordinated efforts with law enforcement, sent notification to the Medical Examiner and District Attorney, interviewed the parents, gathered information from medical collaterals and offered referrals for services.

Initially, the mother was not cooperative with the investigation and refused to be interviewed without an attorney. ACS held a child safety conference in which the mother agreed to participate. During the conference, the mother spoke briefly about the subject child's death. The mother reported that on the morning of 5/14/22, she discovered the child on the floor and the child was purple. The mother stated that within two minutes EMS was at the home. The mother did not know what happened to the child.

ACS interviewed the father, who refused to discuss the subject child or circumstances surrounding her death. The father reported no concern for the twin sibling in the care of the mother. The twin sibling was interviewed at the Child Advocacy Center. The sibling was at his father's home at the time of the child's death. The sibling reported feeling safe at his mother and father's homes and denied any physical discipline. The sibling reported a history of the father physically assaulting the mother, but further stated that the father had changed and was enrolled in necessary services for his anger. The sibling denied being left home alone by the mother, and reported he stayed with their Rabbi and a community member when the mother was out of the country.

Medical records obtained from the emergency department noted that the mother discovered the child at 8:00AM facedown on the ground. The child had urinated on herself, so the mother believed the child had a seizure, but did not observe any

shaking or abnormal movements. The mother was unable to move the child onto her back on her own. The home health aide arrived at 8:45AM and helped the mother turn the child onto her back. The child was purple in the face. The mother immediately called for a local ambulance service. When interviewed, the mother denied that she delayed obtaining medical care for the child. Hospital records over the years indicated that while the child had several medical concerns, the child was a "well appearing child". The record did not reflect the home health aide was interviewed by ACS regarding the incident.

ACS spoke to the twin sibling's services providers to confirm he was in receipt of appropriate medical care. The sibling's pediatrician reported that the sibling had a developmental delay, but was doing much better and was in a regular class in school. The pediatrician reported no concerns for the sibling's development and reported the mother had not expressed any concern. The pediatrician had been seeing the child and sibling since birth. The pediatrician stated that the subject child had more medical concerns than the sibling, but the mother always brought both children in for their visits. While there were no concerns for the medical condition of the child or the child's medical care, it was not documented that ACS obtained information from the subject child's specialists.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062385 - Deceased Child, Female, 12 Yrs	062387 - Mother, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
062385 - Deceased Child, Female, 12 Yrs	062388 - Father, Male, 51 Year(s)	Inadequate Guardianship	Unsubstantiated
062385 - Deceased Child, Female, 12 Yrs	062387 - Mother, Female, 54 Year(s)	DOA / Fatality	Unsubstantiated
062385 - Deceased Child, Female, 12 Yrs	062387 - Mother, Female, 54 Year(s)	Lack of Medical Care	Unsubstantiated
062386 - Sibling, Male, 12 Year(s)	062387 - Mother, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
062386 - Sibling, Male, 12 Year(s)	062388 - Father, Male, 51 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to

				Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Other	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☒	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The record reflected that the child's home health aide was present when the child was found unresponsive and attempts to interview the aide were not documented. In addition, the subject child's specialists were not contacted.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐

Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☒	☐	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
The sibling was enrolled in mental health counseling prior to the death, and continued to engage in weekly sessions.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents declined bereavement services offered by ACS. The father was offered counseling for domestic violence and reported he would discuss it with his current therapist.

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)
06/13/2019	Sibling, Male, 10 Years	Mother, Female, 51 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 10 Years	Father, Male, 48 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged that on 6/6/19, the mother and father became involved in a physical altercation in which they were both the aggressors in the presence of the twin sibling. The role of the subject child was unknown.

Report Determination: Indicated | **Date of Determination:** 09/03/2019

Basis for Determination:
ACS determined that the father's untreated MH had a negative impact on his behavior, as the father physically assaulted

the mother in the presence of the sibling, who expressed feeling angry and desired to intervene to protect the mother. The father had a recent history with ACS for similar concerns resulting in a Neglect Petition and OP. The COS had expired with the family a few days prior to the SCR report. As a result of the incident, ACS filed another Neglect Petition and an OP was reissued on behalf of the mother and children. ACS unsubstantiated IG against the mother due to lack of credible evidence that the mother physically assaulted the father in the presence of the children.

OCFS Review Results:
ACS conducted a thorough investigation, completed all required casework activity, and referred the family to necessary services. There were several face to face contacts made with the family throughout the investigation. ACS spoke to pertinent collaterals and followed up with contacts as needed to discuss the safety of the children. Safety Assessments and the RAP were completed with accurate information. There was supervisory consultation documented throughout 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

Between 2015 and 2018, the father had two indicated CPS investigations and three unfounded CPS investigations. The father was substantiated for Inadequate Guardianship and Lacerations/Bruises/Welts regarding handling the subject child and twin sibling with excessive force.

Between 2015 and 2018, the mother had one indicated CPS investigation and two unfounded CPS investigations. The mother was substantiated for Inadequate Guardianship and Lack of Supervision regarding the twin sibling for locking him outside in the hallway unsupervised.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

Between July 2013 and October 2015, the family was opened for services after an IND CPS investigation against the SF, in which he handled the SS with excessive force. The SM refused to cooperate with ACS. ACS did not note any signs of ongoing abuse or neglect of the CHN during their contacts with the family. The family had a home health aide in place and the SM reported the CHN received needed services through their school.

In 2017, the family agreed to work with services. After the case initiation, the SM refused services because the provider was not a Jewish agency. ACS confirmed the SM was complaint with meeting the medical needs of the CHN and the case was closed.

Between April 2018 and October 2021, ACS filed a Neglect Petition against the SF after he acted violently toward the SM in the presence of the SS and picked up the SC by her face and threw her. The CHN remained in the SM's care with an OP against the SF. The SM enrolled in MH services and the SF enrolled in MH services and parenting classes. The SF completed service goals and was allowed back in the home. In June 2019, the SF assaulted the SM in the presence of the SS. On 6/17/19, ACS filed a Neglect Petition against the SF and the OP was reissued. The SF complied with services, including MH therapy. The COS expired on 9/3/21 and ACS did not request an extension.

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