Child Fatality Report

Report Identification Number: NY-23-002

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

Issue Date: Jun 21, 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 had an open investigation or a CPS monitored services 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: 4 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 01/06/2023
Initial Date OCFS Notified: 01/07/2023

Presenting Information

An SCR report was received and alleged that while in the care of his mother, the 4-year-old subject child experienced difficulty breathing and passed out while on his way to the bathroom. The mother called 911. Emergency medical services arrived and performed cardiopulmonary resuscitation. The child was then transported to the hospital where he was pronounced deceased at 3:17 AM. The child was asthmatic and it was unknown if asthma caused the child's death.

Executive Summary

On 1/7/23, the Administration for Children's Services (ACS) received an SCR report regarding the death of a 4-year-old male child that occurred on 1/6/23. The report alleged DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child. The child resided with his mother and visited with his father. The mother and father had no other children.

ACS completed a joint investigation with law enforcement. Through interviews with the mother and relatives, it was learned that on 1/6/23, the child was home with the mother and the mother's cousin was spending the night. At approximately 1:00 AM, the child woke up and was coughing. The mother began to get herself and the child dressed with the intention of taking him to the hospital. The mother administered the child's nebulizer treatment for his asthma and called emergency medical services. The child removed the nebulizer and ran to use the bathroom while continuing to cough and cry. While using the toilet, the child began to turn blue and when the mother went to pick him up his body started to stiffen. The mother ran the child out to the ambulance and the child was transported to the hospital where he was pronounced deceased.

An autopsy was performed and the child's cause of death was an acute bronchial asthma attack. The child's viral cultures came back and it was uncovered the child had a respiratory tract viral infection with three different viruses found in his system: Adeno Virus, Para Influenza Virus #3, and the Human Rhinovirus. The viral infections were contributory to the child's asthma attack. Law enforcement determined there was no criminality regarding the death and closed their investigation.

ACS provided the family with information on bereavement, mental health counseling, and funeral assistance. ACS found there was not a fair preponderance of evidence to substantiate the allegations against the mother. ACS supported their determination by stating the child was brought to the hospital multiple times regarding his asthma and that while it was unclear if the child had a pediatrician or pulmonologist, it was evident the mother sought emergency care for the child. The investigation was unfounded and closed on 3/8/23.

Through OCFS' review of the fatality investigation, it was discovered the mother missed several medical appointments for the child, including referrals for a pulmonologist and asthma clinic, and that the child did not have a primary care physician. Medical records revealed that the mother was noncompliant with appointments and failed to see that medical care was important to prevent emergency room visits. In addition, the father reported while the child was visiting with him, the father relied on the child to tell him when he needed his medication instead of administering the medications as prescribed. Despite this information, Lack of Medical Care was not added or substantiated against the parents, and Inadequate Guardianship was not substantiated.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
Though ACS gathered sufficient information regarding the allegations, an incorrect determination was made. In addition, the allegation of Lack of Medical Care was not added and substanstanitated.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Though all other casework activity was commensurate with case circumstances, the determination was not supported by the information gathered during the investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The SC was not in receipt of necessary medical care and his medication was not being administered as prescribed. Despite this information, IG was unsubstantiated and LMC was not added and substantiated.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/06/2023 **Time of Death:** 03:17 AM

Time of fatal incident, if different than time of death: 01:00 AM

County where fatality incident occurred: New York
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 and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Using 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	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Other Household 1	Father	No Role	Male	27 Year(s)

LDSS Response

Upon receipt of the SCR report on 1/7/23, 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.

The mother reported that the child was diagnosed with asthma when he was 1 year old. Physical activity and changes in the weather would exacerbate the child's condition. The child was prescribed medication for his condition. ACS observed the child's medicine at the mother's home, including a nebulizer, two inhalers, and an ointment for his skin condition. The mother reported that the child was in the emergency room twice in the week preceding his death due to his asthma, once on 12/31/22 and on again on 1/3/23. The child was discharged the same day. On 1/6/23 at approximately 1:00 AM, the child woke up and was coughing and crying. The mother was preparing to bring the child to the hospital. The mother called an ambulance and administered the child's nebulizer treatment. The child ripped the nebulizer out of his mouth, alerting the mother he had to go to the bathroom. The child urinated on himself and then while using the toilet, began turning blue and his body started to stiffen. The mother grabbed the child and ran him downstairs in her arms. The mother

met the ambulance outside, and the child was transported to the hospital where he was pronounced deceased at 3:17 AM.

ACS interviewed the father, maternal grandmother, and paternal grandmother regarding the child's medical condition. The child visited with the father and grandparents consistently throughout the year and they were aware of his asthma. The child visited with the maternal grandmother from 12/20/22 through 12/23/22 and she had all his medication. The child then went to visit the paternal family until 12/29/22, and the maternal grandmother sent the medication with the child. The father did not appear to have knowledge of how often the child should receive his medication and stated the child would tell the father when he needed it. The father reported he did not think the child had a primary care doctor or pulmonologist. ACS attempted to interview the mother's cousin who was present at the time of the death; however, another relative intervened and would not allow the interview to continue.

ACS gathered information from medical collaterals and obtained pertinent medical records. A review of medical records showed that the child had twenty-one emergency room visits and at least four admissions related to bronchiolitis, asthma, and reactive airway disease. Discharge planning included follow-up with a pulmonologist. One hospital reported the mother was noncompliant with appointments and failed to see that medical care was important to prevent emergency room episodes. The child was recommended to attend an asthma clinic in 2020, and the mother did not follow up with the appointment. The child was most recently brought to the hospital on 12/31/22 and 1/4/23 for his asthma. The child was treated and sent home. The pediatrician whom the mother reported provided the child with primary care denied the child was a patient at their office.

During initial interviews with the mother, the record did not reflect if the mother was asked if she had administered the child's medication as prescribed in the days leading up to the death. When ACS learned of the mother's non-compliance with medical appointments and the child's lack of a primary care physician, they documented additional attempts to gather more information from the mother; however, she was not responsive to attempted phone calls and home visits. At case closure, ACS determined it did not appear that the child had a primary care physician or had been to a pulmonologist regarding his asthma.

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: Medical Examiner

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: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063539 - Deceased Child, Male, 4 Yrs	063608 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
063539 - Deceased Child, Male, 4 Yrs	063608 - Mother, Female, 21 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?	☒	☐	☐	☐
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:
ACS documented efforts to interview the father face-to-face; however, he did not make himself available and ACS interviewed him over the phone. ACS attempted to interview the mother's cousin.

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered bereavement, mental health counseling and funeral assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)	Status/Outcome	Compliance Issue(s)
07/07/2022	Deceased Child, Male, 3 Years	Mother, Female, 20 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Male, 3 Years	Mother, Female, 20 Years	Lack of Medical Care	Far-Closed	
	Deceased Child, Male, 3 Years	Father, Male, 26 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 3 Years	Father, Male, 26 Years	Lack of Medical Care	Far-Closed	

Report Summary:
An SCR report was received that alleged the then 3-year-old subject child was diagnosed with severe asthma. Since February 2021, the child was at the hospital 8 times with 3 admissions due to his acute asthma attacks. The hospital visits and admissions were the result of the parents' failure to properly administer the child's medication. The child was admitted to the hospital on 1/4/22. The child was medically cleared to be discharged; however, the mother went out of town, the father was being verbally abusive and hostile towards the staff, and there was no one appropriate at the hospital to address the child's discharge plan.

OCFS Review Results:
ACS determined the SCR report was Family Assessment Response (FAR) eligible. The FAR approach was discussed with the parents and FAR tools were completed with the parents and SC. It was learned from medical collaterals that the SC was hospitalized several times due to his asthma. The SM was not administering the SC's medication as often as necessary. The hospital and ACS reviewed with the mother how the medication should be administered. The SC was admitted to the hospital for an asthma attack again during the assessment period. The record did not reflect ACS contacted medical collaterals to identify if the mother brought the SC for necessary medical follow-up appointments.

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

Issue:
FAR-Failure to Address Reported or Identified Concerns

Summary:
The SC had been to the emergency room multiple times due to concerns for his asthma. The SC was recommended for follow-up medical care after his discharge from the hospital and was referred to a pulmonologist. The mother missed the SC's appointment on 1/28/22. The record did not reflect if the necessary appointments were attended at the time the case was closed.

Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)

Action:
When a report alleging maltreatment of a child is assigned to FAR, CPS must engage the family in an assessment of: the concerns reported to the State Central Register, any family-identified needs and concerns that may impact the safety or risk of children, and the family's strengths and resources that could be engaged to address the identified concerns.

Issue:
FAR-Timely/Adequate Family-Led Assessment Guide

Summary:
The record did not reflect the Family-Led Assessment Guide (FLAG) was completed in collaboration with the family.

Legal Reference:
18 NYCRR 432.13 (e)(2)(iii)-(v)

Action:
ACS must complete the family-led assessment guide (FLAG). Family assessment response staff must engage the family in an examination of the issues of concern to the child protective service as well as the family's strengths, concerns, and needs. The assessment must be conducted using a Family Led Assessment Guide (FLAG), as specified by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/26/2022	Deceased Child, Male, 3 Years	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
An SCR report alleged that on 4/26/22, the mother and the parent substitute were involved in a dispute when the mother became physical with the parent substitute and stabbed him in the arm. The then 3-year-old subject child was present but

it was unknown if he witnessed the violence. There was a history of violence perpetrated by the parent substitute a year prior to the SCR report. It was unknown if the child was present for that incident.

Report Determination: Indicated | **Date of Determination:** 06/24/2022

Basis for Determination:
ACS determined that the mother failed to meet a minimum standard of care for the child as she engaged in a violent physical altercation with the parent substitute while the child was in the home. The mother was arrested because of the incident and the investigation was indicated.

OCFS Review Results:
ACS attempted contact with the source, interviewed the mother and family members, spoke to collaterals, and completed home visits. It was determined the mother stabbed the parent substitute and was arrested. There was an OP against the mother regarding the child. The child went to live with the maternal grandmother and her home was assessed. There were ongoing criminal court proceedings and an active OP at case closure. ACS had a safety plan documented in the final safety assessment. ACS supervisory staff instructed CPS to consult with their legal department; however, the record did not reflect this was completed and the investigation was closed.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The record did not reflect diligent efforts to speak with the father regarding the SCR report, despite his active involvement with the child during the prior family assessment response case.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Issue:
Assessment as to need for Family Court Action

Summary:
A supervisory progress note included instructions to contact legal regarding the need for family court action. The record did not reflect preventive services were offered, or legal was contacted, and the investigation was closed with a safety plan in place.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:
ACS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

[redacted]

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

In 2019, an SCR report alleged that the mother was not addressing the child's medical conditions and that the parents got in a fight at the hospital while the mother was drinking alcohol. The investigation was unfounded, as ACS determined there was no evidence to support the mother was not addressing the concerns for the child following his surgery for a medical condition. ACS further determined there was no evidence of alcohol use and no evidence the parents fought near the child.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

Between January 2019 and March 2019, the mother had an open preventive services case. The case was opened after the SCR report in 2019. There were concerns for domestic violence perpetrated by the father, violent behaviors by the mother resulting in her being on probation, and the child was born with medical conditions which he received surgery for. ACS documented they were considering filing a petition for court-order services for the parents. The record did not reflect a petition was filed. The case was closed and the reason for the closure was not documented. The mother and the subject child continued to be listed as service recipients on the maternal grandmother's services case. The grandmother's services case closed in September 2020 and noted no concerns for the subject child.

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