Child Fatality Report

Report Identification Number: NY-23-003

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

Issue Date: Jun 30, 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: 6 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/26/2022
Initial Date OCFS Notified: 01/10/2023

Presenting Information

New York City Administration for Children's Services (ACS) was notified by the maternal grandmother the subject child died on 12/26/22. There was an open FAR case at the time of the child's death regarding the 15-year-old maternal aunt. ACS completed the 7065-Agency Reporting Form and notified the regional office untimely, on 1/10/23.

Executive Summary

On 12/29/22, ACS was notified by the maternal grandmother that the 6-month-old male subject child passed away on 12/26/22. ACS had an open FAR case with the maternal grandmother, which began on 11/7/22, due to concerns of educational neglect regarding the 15-year-old aunt. At the time of his death, the subject child resided with his mother, the 5 and 1-year-old siblings, the maternal grandmother, and the 15, 13, and 10-year-old maternal aunts.

ACS made a home visit and learned that several of the children in the home had been sick about a month prior to the subject child's death. The maternal grandmother reported the mother had taken the subject child to the hospital for respiratory concerns sometime prior to 12/23/22. On an unknown date the subject child was transferred to another hospital, where he died on 12/26/22. Further details regarding the subject child's medical care at the hospital was unknown. The maternal grandmother reported to ACS the subject child had died from a virus; however, there was no documentation in the record regarding the cause of the subject child's death. The record did not reflect that ACS spoke with the mother and father of the subject child regarding the death.

At the time this report was written, it was unknown if an autopsy was completed. The record reflected ACS contacted the forensic pathologist at the medical examiner's office, confirmed the subject child's date of death, and learned that the death was ruled to be the result of natural causes. The forensic pathologist further stated that information would have to be obtained from the medical examiner and hospital to determine if there were contributing factors regarding the death. The record did not reflect any further information was gathered from medical professionals.

ACS offered the mother burial assistance and bereavement counseling, and the mother declined services. The mother planned for the 5-year-old sibling to receive counseling services at school. ACS completed a referral for the maternal grandmother and the aunts' regarding bereavement counseling; however, the maternal grandmother declined the services. ACS provided the family with a list of community-based resources. ACS assessed the siblings as safe in the care of the mother and the aunts were assessed as safe with the maternal grandmother.

The record did not reflect that ACS gathered information regarding the circumstances of the death of the subject child to determine if there was any abuse or maltreatment against the mother or maternal grandmother. The open FAR case was completed, and the case was closed on 1/6/23. ACS notified the New York City Regional Office (NYCRO) of the death untimely, on 1/10/23.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The fatality was not SCR reported; therefore, certain casework activity was not required.

Was the decision to close the case appropriate? N/A

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:
Casework activity was not commensurate with the case circumstance.

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: 12/26/2022 **Time of Death:** 10:37 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Kings

Was 911 or local emergency number called? No

Did EMS respond to the scene? No

At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown

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	No Role	Male	6 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	41 Year(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)
Deceased Child's Household	Other Child - Maternal Aunt	No Role	Female	13 Year(s)
Deceased Child's Household	Other Child - Maternal Aunt	No Role	Female	10 Year(s)
Deceased Child's Household	Other Child - Maternal Aunt	No Role	Female	15 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)

LDSS Response

At the time of the subject child's death there was an ongoing FAR investigation that involved the 15yo aunt's truancy. The mother, subject child, and the two siblings were residing in the home of the maternal grandmother. ACS made a home visit and the home met minimal standards. The mother reported she was co-sleeping with the subject child prior to his death because there was not enough room in the one-bedroom apartment to set up the portable crib for the child. ACS reviewed safe sleep recommendations with the mother and provided another pack-n-play to the mother for the subject child. On 12/23/22, ACS learned from the maternal grandmother during a phone call that the subject child was taken to a hospital over the weekend because he was sick, and he was being transferred to another hospital on that same day. The maternal grandmother reported the child had a viral infection or Respiratory Syncytial Virus (RSV).

In response to the fatality, ACS completed a home visit on 12/29/22 with the maternal grandmother and learned that the subject child died on 12/26/22 at the hospital. The mother and siblings were not at the home during this visit. ACS contacted the mother by phone on 1/3/23, and explained burial assistance; however, the record did not reflect that ACS asked the mother about the circumstances surrounding the subject child's death. On 1/4/23, ACS completed a video call with the mother and the SSs were observed. ACS inquired if the hospital referred the mother to services; however, ACS did not inquire about the circumstance surrounding the subject child's death. The mother declined bereavement counseling offered by ACS and said the 5yo SS would receive counseling at school.

The record did not reflect that ACS interviewed the mother regarding child's death. There was no information in the record that the father of the subject child was identified, notified, or interviewed by ACS regarding the death of the child. The record did not reflect that ACS contacted medical professionals after speaking with the forensic pathologist at the ME's office to determine if there were any contributing factors regarding the child's death.

On 2/17/23, ACS received a FAR report that alleged ongoing concerns for the 15yo MA not attending school and she was not receiving services. The 15yo MA had missed 99 days of school and was failing as a result. The MGM was aware and failed to adequately intervene or take corrective action.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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:
This was not an SCR reported fatality; therefore, certain investigative activities were not required.

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: As there was no SCR report surrounding the fatality, the completion of safety assessments was not required; however, ACS documented an assessment of the siblings' safety following the death and there were no concerns.				

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐

Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS offered the family services, and they declined. The family was provided with a list of community-based resources.

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:
ACS offered services to the MGM and the mother on behalf of the children, and they declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS offered services to the MGM and the mother, and they declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ Smoked tobacco
☐ Used illicit drugs
☐ Used prescription drugs
☒ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none of the issues listed noted in case record

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)
11/07/2022	Other Child - Maternal Aunt, Female, 15 Years	Grandparent, Female, 41 Years	Educational Neglect	Far-Closed	Yes
	Other Child - Maternal Aunt, Female, 15 Years	Grandparent, Female, 41 Years	Lack of Medical Care	Far-Closed	

Report Summary:
An SCR report that was tracked FAR alleged the 15yo MA missed 40 days of school and was failing as a result. The 15yo MA had an IEP and was missing speech therapy and counseling as a result of her not attending school. The MGM was aware and failed to ensure the 15yo MA went to school.

OCFS Review Results:
ACS met with the family, and they consented to FAR. ACS completed the 7-day safety assessment on time and accurately. ACS engaged the family and spoke with all household members. The FLAG was completed with the family and home visits were conducted. The record did not reflect that FAR notices were sent to any of the non-custodial/out-of-the home fathers as required.

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

Issue:
FAR-Failure to Provide Notice of Report

Summary:
The record did not reflect that ACS sent the required notification of the report to the non-custodial/out-of-household fathers regarding their children. There is no legal requirement to further involve the non-custodial/out-of-household parent in the FAR process.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:
No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian, non-custodial or out-of-household parent or other person legally responsible for the child or children named in the report.

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response

Summary:
According to the case record, ACS did not make adequate attempts to determine the circumstances of the child's death or whether the child's death was a result of abuse or neglect by the mother or MGM. The record did not reflect that ACS interviewed the mother regarding the child's death. There was no information in the record that the father of the subject

child was identified, notified, interviewed, or offered services by ACS regarding the death of the child. The record did not reflect that ACS contacted medical professionals after speaking with the forensic pathologist at the ME's office to determine if there were any contributing factors regarding the child's death.

Legal Reference:

18 NYCRR 432.13 (a)(1-4)

Action:

ACS will make diligent efforts to contact collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor so as to respond to potential safety concerns in a timely and effective manner. (CPS Manual Chapter 14 section L page L-1)

Issue:

Child's death not reported to the RO in a timely manner

Summary:

ACS learned of the SC's death on 12/29/2022 during an open FAR case. Though required to notify the New York City Regional Office within 24 hours, ACS did not notify NYCRO until 1/10/23 after the FAR case was closed.

Legal Reference:

18 NYCRR 441.7(c)

Action:

All authorized agencies must report to the Regional Office the death of a child involved in an open protective or preventive case within 24 hours of death or as soon thereafter as the agency becomes aware of the death.

[redacted]

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

On 7/16/18, the 15, 13, and 10yo MA's were listed on an unfounded CPS case with allegations of IG and IF/C/S, against the MGM and the mother.

Known CPS History Outside of NYS

There was no known history outside of New York State.

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