Child Fatality Report

Report Identification Number: NY-23-036

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

Issue Date: Sep 13, 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: 5 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 04/02/2023
Initial Date OCFS Notified: 04/02/2023

Presenting Information

On 4/2/23, New York City Administration for Children's Services (ACS) received two SCR reports that alleged the mother, the mother's partner, and the child took a nap. When the mother woke up, she found the child unresponsive. At about 4:17PM, one of the adults called 911 and the mother's partner began CPR on the child. EMS arrived at the home and the child was on his back in the living room, not breathing, and had no heartbeat. EMS began resuscitative measures and transported the child to the hospital. Hospital staff continued life-saving measures; however, were unsuccessful and the child was pronounced deceased at 4:59PM. The child was an otherwise healthy child, and the parents had no explanation for the child's death.

Executive Summary

This fatality report concerns the death of a 5-year-old male subject child that occurred on 4/2/23. At the time of his death, the subject child resided with his mother and the mother's partner. The subject child had no contact with his father as there was an order of protection in place. The mother's partner had a 10-year-old child who resided with her mother. ACS assessed the safety of that child, and she remained in the care of her mother.

The mother and the mother's partner told ACS the subject child was up all night on 4/2/23. The subject child was not feeling well, he was vomiting, and he had a fever. The mother and the mother's partner did not seek medical treatment and gave the subject child Tylenol and Pedialyte. The mother's partner went to sleep around 6:00AM and the mother stayed up with the subject child. Around 4:00PM, the mother's partner was awoken by the mother yelling something was wrong with the subject child. The mother's partner went to the subject child's bedroom and found him unresponsive. The mother's partner called 911, brought the subject child to the living room, and was instructed by the dispatcher how to perform cardiopulmonary resuscitation on the subject child until first responders arrived. Emergency medical services arrived at the home, took over resuscitative measures, and transported the subject child to the hospital. Hospital staff continued life-saving measures; however, were unsuccessful and the subject child was pronounced deceased at 4:59PM.

The medical examiner was notified and performed an autopsy on the child; however, a cause and manner of death were pending at the time this report was written. The record reflected that ACS spoke with the medical examiner and that the subject child was diagnosed with a rare congenital vascular disorder, Klippel-Trenaunay syndrome (KTS). Further testing was needed to determine if KTS contributed to the subject child's death. Law enforcement initiated their investigation, and it remained open pending the final autopsy results.

Bereavement services and burial assistance were offered to the mother and her partner, and they accepted. The mother of the partner's 10-year-old child was provided with a list of community-based resources for grief counseling. The mother's partner was not listed on the risk assessment profile as a secondary caretaker; although, he was a primary caretaker of the subject child, and his child visited the home on a regular basis. ACS unsubstantiated the allegations of DOA/Fatality against the mother and the mother's partner and substantiated the allegations of Inadequate Guardianship and Lack of Medical Care.

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:**
  - **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:
ACS made an appropriate determination based on the evidence obtained throughout the investigation.

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:
Casework activity was not commensurate with the case circumstances. The mother's partner was not listed on the RAP as a secondary caregiver; therefore, the RAP was scored inaccurately.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	ACS did not identify a secondary caretaker on the RAP. The mother's partner was a regular caretaker for the SC, was a confirmed subject, and his child visited the home on a regular basis. Therefore, the RAP was completed and scored inaccurately.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/02/2023 **Time of Death:** 04:59 PM

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

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

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	5 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	40
Other Household 1	Father	No Role	Male	48 Year(s)
Other Household 2	Other Child - The mother's partner's child	No Role	Female	10 Year(s)

LDSS Response

On 4/2/23, ACS received 2 SCR reports regarding the death of the SC. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the source of the reports, completed a CPS history check, and informed the DA of the fatality.

ACS interviewed the SM and the mother's partner regarding the events leading up to the SC's death. The SM and the mother's partner said the SC was sick for a few days prior to his death; he was vomiting, had a fever, there was blood in his urine, had low energy, was drowsy, and did not want to eat. The SM provided the SC with Pedialyte and Tylenol throughout the day. The SM and the mother's partner reported they were up all night checking on the SC in his bedroom, and gave him Tylenol, Pedialyte, and changed his diaper. Around 6:00AM on 4/2/23, the mother's partner went to sleep in another room, and he was awoken at about 4:00PM, by the SM screaming there was something wrong with the SC. The

mother's partner went to the SC's bedroom and the child was unresponsive and pale. The mother's partner immediately called 911 and was instructed by the 911 operator how to perform CPR on the SC until first responders arrived.

ACS learned the SC was born with a rare congenital vascular disorder, Klippel-Trenaunay syndrome (KTS). The SC's left leg was larger than his right, and there was vascular malformation. The SC had trouble walking and had pain and discomfort in his leg. The SM was not consistent with the SC receiving routine medical care regarding his medical condition and the SC had not been seen since 2020.

ACS met with the father of the SC and made him aware of the SC's passing. The father had no contact with the SC in the past 3 years. There was a criminal order of protection in place protecting the SC from the father until 2024. A criminal order of protection was also active protecting the SM from the father until 2029. The father was unaware of any medical diagnosis for the SC.

The mother's partner's 10yo child was seen and interviewed at her mother's home by ACS on 4/3/23. She was free of any marks or bruises and was assessed as safe with her mother. The 10yo child resided with her mother and had visitation with the mother's partner every other weekend. The mother of the 10yo child had no concerns for the SM or the mother's partner. ACS provided the mother of the 10yo child with community-based resources for grief counseling.

ACS spoke with the medical examiner's office regarding the SC's death. The record reflected the ME reported the death could have been due to the child's KTS, but further studies were needed and that could take 3-6 months. The bladder was observed with blood that could be related to the SC's vascular malformation. A rapid drug screen was completed, and the results were negative.

ACS contacted collateral sources, including LE, family resources, school, EMS, and hospital staff. Medical documentation was received from the pediatrician regarding the SC, and the SC was not up to date with well-child visits or immunizations prior to his death. ACS contacted the pediatrician and school staff regarding the mother's partner's 10yo child and there were no concerns.

ACS indicated and closed the CPS investigation. ACS unsubstantiated the allegations of DOA/Fatality against the SM and the mother's partner and substantiated the allegations of IG and L/M/C. ACS found a fair preponderance of evidence that the SM and the mother's partner were aware in the days leading to the SC's death that the SC was ill; however, they did not seek medical treatment and failed to meet a minimum degree of care for the SC. The SM and mother's partner failed to ensure the SC was taken for routine medical care regarding his rare congenital vascular disorder.

Official Manner and Cause of Death

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

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
064604 - Deceased Child, Male, 5 Yrs	064605 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
064604 - Deceased Child, Male, 5 Yrs	064605 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
064604 - Deceased Child, Male, 5 Yrs	064605 - Mother, Female, 33 Year(s)	Lack of Medical Care	Substantiated
064604 - Deceased Child, Male, 5 Yrs	064606 - Mother's Partner, Male, 40	DOA / Fatality	Unsubstantiated
064604 - Deceased Child, Male, 5 Yrs	064606 - Mother's Partner, Male, 40	Inadequate Guardianship	Substantiated
064604 - Deceased Child, Male, 5 Yrs	064606 - Mother's Partner, Male, 40	Lack of Medical Care	Substantiated

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?	☒	☐	☐	☐

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	☒	☐	☐	☐

Explain:
There were no surviving children residing in the home. The child of the mothers' partner resided with her mother and visited the home. The mother's partner was not listed on the RAP although his child visits the home regularly and he had a regular caretaking role of the SC.

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.

Have any Orders of Protection been issued? No

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 bereavement services, burial assistance, and provided a list of community-based resources, which the family accepted. It was unknown if the family followed through with the services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS offered the mother and the mother's partner bereavement services and burial assistance, and they accepted.

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

There is no CPS investigative history in NYS within three years prior to the fatality.

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

In 2017, the allegations of IG and PD/AM were substantiated against the mother regarding the SC. The SC tested positive for drugs at birth. ACS filed an Article 10 Neglect petition against the mother. The SC was placed in the care of his father and a services case was opened.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Preventive Services History

ACS opened a services case on 10/6/17. A Neglect petition was filed against the mother on 10/10/17, and the SC was released to the father. On 12/14/17, the SC was released to the mother and father with court ordered supervision. The mother completed her required outpatient substance abuse treatment, parenting classes, and maintained her sobriety. The services case was closed on 8/16/18.

ACS opened a services case on 4/1/19 regarding a court ordered investigation that was received from family court. The mother petitioned for sole legal and physical custody of the SC. ACS made efforts to locate the father but were unsuccessful. The mother was granted sole custody of the SC and the services case was closed on 5/8/19.

ACS opened a services case on 11/12/21, regarding a court ordered investigation that was received from family court. The father filed for visitation and custody of the SC against the mother. ACS conducted interviews, home visits, and spoke with collateral contacts. There were 3 active orders of protection against the father, protecting the mother and the child until 2022, 2024, and 2029. The report was sent to family court and the services case was closed on 12/21/21. The SC remained in the custody of the mother.

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