Report Identification Number: NY-23-103

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

Issue Date: Feb 26, 2024

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
Jurisdiction: Queens
Date of Death: 09/12/2023
Age: 11 year(s)
Gender: Male
Initial Date OCFS Notified: 10/23/2023

Presenting Information

An SCR report received on 10/23/23 alleged that on 9/9/23, the mother was aware the subject child was having asthma-related issues and not feeling well but did not seek medical treatment or provide asthma treatment to the child because the mother was impaired on unknown substances and alcohol. At 3:00AM on 9/10/23, the mother became aware the child stopped breathing, called 911, and drove the child to the hospital. The child was pronounced brain dead on 9/10/23. The mother had a history of substance misuse and failing to provide for the child and sibling. On 8/25/23, the mother left the home without making an adequate plan for the children and did not return until 8/27/23. The home was filthy, and the mother did not clean the home or the children's clothes. The children resided in unsanitary conditions that were a health hazard because the mother was misusing substances despite having the means to provide for the children.

Executive Summary

This report concerns the death of the 11-year-old subject child that occurred on 9/12/23. The Administration for Children's Services (ACS) received a report regarding the child's death about one month later, on 10/23/23. At the time of the child's death, he resided with his mother and two siblings, ages 12 and 18.

In the early morning hours of 9/12/23, around 2:00AM, the subject child woke the mother, stating he could not breathe well. The mother provided a nebulizer treatment and called 911. Approximately 12 minutes passed, and emergency medical services had not yet responded. The mother then drove the child to the hospital and flagged down the ambulance en route. The child was intubated and transported to the hospital. Cardiopulmonary resuscitation (CPR) was performed and return of spontaneous circulation was achieved at approximately 18 minutes. The child was stabilized for transport to a higher level of care at another facility. Life-saving measures continued. Video EEG testing showed profound diffuse disturbance in cortical neuronal function and a CT showed diffuse anoxic brain injury. Testing for death by neurologic criteria (brain death) was performed with no response and the child was pronounced deceased at 1:57PM.

The medical examiner was notified of the death and did not accept the case. Discharge records from the hospital declaring the death indicated the cause of death was brain death. The child presented in cardiac arrest, secondary to status asthmaticus (acute severe asthma). The manner of death was considered natural, and the child was cremated.

Law enforcement became involved upon receipt of the SCR report on 10/23/23, participated in a joint home visit with ACS, and closed their investigation without charges that same date.

ACS interviewed the source of the report, the mother, siblings, and relevant collaterals. The 12-year-old sibling was assessed to be safe and remained in the mother's care.

ACS unsubstantiated the allegations against the mother. ACS determined through collateral contact that the mother had adequate provisions in place to treat the subject child's asthma, was compliant with his treatment, and took appropriate action when the child required medical treatment. A home visit and interviews revealed the home had adequate provisions for the children, and the children were up-to-date medically with no concerns noted.

The mother was offered services in response to the fatality, which she declined. The subject child's father was unable to be located during the investigation.

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

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:
While the family participated in the initial home visit and signed requested releases of information for medical providers, the mother ceased communication with ACS following the initial contact. A legal consult was held and it was determined there was no basis to file in court to compel ongoing ACS involvement and the case was closed on 12/20/23.

Required Actions Related to the Fatality

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

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The subject child's date of death was incorrectly recorded in CONNECTIONS. The date of death was recorded as 9/10/23; however, upon learning the accurate date, the record should have been updated to reflect a date of 9/12/23.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual and objective to best reflect

	accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/12/2023 **Time of Death:** 01:57 PM

Time of fatal incident, if different than time of death: 02:00 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	Alleged Victim	Male	11 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	18 Year(s)
Other Household 1	Father	No Role	Male	39 Year(s)

LDSS Response

On 10/23/23, ACS received an SCR report regarding the subject child’s death, which occurred a month prior, on 9/12/23. Within the first 24 hours, ACS contacted the source of the report, completed a CPS history check, notified the DA’s office, and coordinated with law enforcement to conduct a joint home visit.

ACS interviewed the mother regarding the events leading up to the child’s death. The mother recalled the day prior to the fatal incident, the child was behaving normally and presented with no issues. He had gone to bed the evening of 9/11/23

and then the mother was woken up by the child at 2:00AM the next morning. The child told the mother he could not breathe well, so the mother assisted him with a nebulizer treatment and called 911. About 12 minutes passed and EMS had not responded. The child took his nebulizer mask off and said to the mother, “drive me, I don’t want to die.” The mother picked the child up, brought him to the car, and began driving toward the hospital. While en route, she saw the ambulance and flagged them down for assistance. The mother stated they intubated him, and she recalled hearing one of the technicians comment they thought they “did it wrong.” The mother became upset at that point, and an additional ambulance and the fire department arrived for assistance. The mother felt they were not moving with a sense of urgency as they were driving slowly without the sirens. Regarding the allegations stating the mother was under the influence at the time of the fatal incident, the mother denied substance misuse and stated she had interacted with so many people that day, if there was concern for her being under the influence, it would have been addressed at that time, not a month later.

ACS attempted to interview the 12 and 18yo siblings, both of whom expressed they did not wish to discuss their brother’s death. The 18yo stated the mother tried her best to save the child and she was a great mother. The sibling corroborated that the mother called 911 right away and drove the child to the hospital when EMS did not respond timely. Both the 12 and 18yo siblings denied substance misuse in the home.

ACS obtained records from both sending and receiving hospitals, as well as the children’s pediatrician. The subject child and 12yo sibling were up to date on well-child exams and immunizations. The subject child’s last asthma assessment was on 10/12/22, and the next one was scheduled for 10/2/23. The pediatrician stated based on the last assessment, the child’s asthma seemed well controlled. Recent prescription refills were completed for albuterol (Proventil) and albuterol HFA (Ventolin) on 9/11/23 and 9/5/23, respectively. School staff reported no recent concerns and a marked improvement since ACS’s last involvement in 2020. The children presented to school in neat and clean clothes, and the mother was receptive to school staff and responded appropriately when contacted by the nurse regarding the subject child.

The mother became uncooperative with ACS following the initial home visit and signing of releases. The 12yo sibling continued to be assessed through school visits and reported nothing of concern. A legal consult was held regarding the mother’s lack of cooperation; however, it was determined there was no basis at that time to file in court to compel the mother to cooperate. No ongoing safety factors had been identified and the mother had declined fatality-related service referrals; therefore, the case was determined and closed on 12/20/23.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066069 - Deceased Child, Male, 11 Year(s)	066072 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated

066069 - Deceased Child, Male, 11 Year(s)	066072 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066069 - Deceased Child, Male, 11 Year(s)	066072 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
066069 - Deceased Child, Male, 11 Year(s)	066072 - Mother, Female, 38 Year(s)	Lack of Medical Care	Unsubstantiated
066070 - Sibling, Female, 12 Year(s)	066072 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066070 - Sibling, Female, 12 Year(s)	066072 - Mother, Female, 38 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
The mother became uncooperative following the initial home visit and did not participate in further interviews. The RAP was completed and resulted in a low risk rating, consistent with the most recently completed RAPs in 2019 and 2020.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No

Explain:

The mother was offered referrals for bereavement services; however, declined, stating she was receiving her own services. It was not documented if those services included the 12yo sibling. The child's father was unable to be successfully located during the investigation.

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

1/23/20 – 3/24/20 ACS unsubstantiated allegations of Excessive Corporal Punishment, Lacerations/Bruises/Welts, and Inadequate Guardianship against the mother regarding the subject child and 12yo sibling.

10/16/19 – 12/13/19 The family participated in a FAR case with ACS, initiated by allegations of Inadequate Guardianship and Lack of Medical Care against the mother regarding the subject child.

5/9/19 – 6/27/19 ACS unsubstantiated allegations of Inadequate Guardianship, Lacerations/Bruises/Welts, and Lack of Medical Care against the mother regarding the subject child.

4/12/18 – 6/8/18 ACS substantiated allegations of Excessive Corporal Punishment and Inadequate Guardianship against the mother and her paramour regarding the subject child, 12yo, and 18yo siblings, as well as Lack of Medical Care against the mother regarding the subject child.

2/10/12 – 3/30/12 ACS substantiated allegations of Inadequate Guardianship and Lack of Supervision against the mother regarding the now 12 and 18yo siblings, as well as Inadequate Guardianship against the father. An FSS was opened due to judicial intervention.

6/12/07 – 8/21/07 ACS substantiated allegations of Inadequate Food/Clothing/Shelter, Inadequate Guardianship, Lack of Medical Care, and Lack of Supervision against the mother regarding the now 18yo sibling. An FSS was opened due to judicial intervention.

Known CPS History Outside of NYS

The mother had CPS history in New Jersey in 2005 regarding the now 18yo sibling.

Preventive Services History

3/2/12 – 7/26/13 The mother, father, subject child, and siblings were listed on an FSS due to court ordered supervision, which was resolved with an adjournment in contemplation of dismissal. It was thought the family could benefit from parenting skills, domestic violence counseling, and homemaking. Goals were learning to provide appropriate supervision to the siblings and attending counseling and batterer's accountability classes. Court ordered supervision ended 7/19/13. The mother was receiving MH counseling and the parents reportedly got along well. Homebased services were in place through a community-based program and there had been no reported domestic incidents.

6/28/07 – 2/12/09 The mother and now 18yo sibling were listed on an FSS. The sibling was briefly removed from the mother's care on 8/7/07 and returned on 8/16/07 with court ordered supervision. A neglect finding was made on 10/20/07. Initial goals included the mother learning how to budget to prioritize meeting the sibling's needs, learning about child development expectations, and maintaining sobriety. Services ended when the family achieved the goals in the initial service plan. The mother showed improvement in providing for the sibling's basic needs. The mother completed a parenting program, drug tests had been negative, and the mother had enrolled in MH counseling.

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