Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-021

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

Issue Date: Jun 10, 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
Age: 8 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 03/24/2017
Initial Date OCFS Notified: 03/16/2024

Presenting Information

An SCR report was received on 3/16/24, alleging on an unknown date in either 2015 or 2016, the SM used force to discipline the then 7yo SC. The SM physically beat the SC as punishment for not doing his homework. As a result, the SC suffered difficulty breathing, causing a lack of oxygen and then his death. The SM had a history of physically assaulting the SC and another unknown child. As a result, the SC and other unknown child sustained marks and bruises all over their bodies.

Executive Summary

The New York City Administration for Children's Services (ACS) received an SCR report on 3/16/24, regarding the death of an 8yo male subject child. The SCR report contained allegations of Excessive Corporal Punishment, Inadequate Guardianship, Lacerations/Welts/Bruises, and DOA/Fatality against the subject mother regarding the subject child and allegations of Inadequate Guardianship and Lacerations/Welts/Bruises against the subject mother regarding the 1-month-old nephew.

The SCR report alleged the subject child passed away in 2015 or 2016; however, ACS was able to determine the subject child was pronounced deceased on 3/24/17. At the time of the subject child's death, he was residing with his mother; however, it is unclear who else was residing in the home with them at the time. There were four surviving siblings, ages 2, 4, 7, and 10-years-old. At the time this SCR report was received, the surviving siblings were, ages 9, 11, 17, and 18-years-old. ACS made diligent efforts to immediately assess the safety of the surviving siblings; however, the subject mother was uncooperative. ACS was eventually able to observe the 9, 11, and 17-year-old surviving siblings and determined there were no immediate safety concerns. At the time this report was written, ACS had made unsuccessful attempts to assess the 1-month-old nephew. The 18-year-old adult sibling identified herself as the 1-month-old nephew's mother and refused ACS contact.

ACS learned on 3/20/17, the subject child had an asthma attack and could not breathe. As a result, the subject mother called 911 and the subject child was transported to the hospital. The subject child remained in the hospital until he succumbed to his illness. The subject mother refused to provide more information and refused to sign any forms for ACS to obtain the death certificate and medical information.

ACS contacted the medical examiner's office who reported they did not have information on the subject child. It was reported not all cases were brought to the medical examiner's office; most cases they received were cases with suspicious circumstances. Law enforcement was not contacted.

The subject mother reported they were provided with bereavement services at the time of the subject child's death in 2017. ACS appropriately unsubstantiated the allegation of Inadequate Guardianship, Excessive Corporal Punishment, Lacerations/Bruises/Welts, and DOA/Fatality against the subject mother regarding the subject child. ACS lacked information to substantiate the allegations of Inadequate Guardianship and Lacerations/Bruises/Welts against the subject mother regarding the 1-month-old nephew. Due to the family's lack of cooperation, ACS was unable to assess the safety of the 1-month-old nephew.

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

Explain:
ACS made diligent efforts to gather all relevant information to make a determination regarding all of the allegations; however, they were unable to see the 1-month-old nephew due to the family's lack of cooperation and therefore could not determine if he sustained any marks or bruises. The allegations against the SM regarding the SC were appropriately unsubstantiated.

Was the decision to close the case appropriate? Unknown

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 case circumstances due to ACS not collaborating with LE regarding the fatality report.

Required Actions Related to the Fatality

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

Issue:	Failure to utilize an approved MDT
Summary:	ACS failed to contact and collaborate with Law Enforcement regarding the child fatality.
Legal Reference:	SSL 423(6); SSL 424 (5-a); 10-OCFS-LCM-09
Action:	CPS reports with allegations of sex abuse and cases that involve the death of a child, where an ACS

	has chosen to establish an OCFS approved multidisciplinary team (MDT), must be investigated by the MDT. In local districts where no MDT has been established, ACS must jointly investigate the abovenamed CPS cases with law enforcement.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/24/2017 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 03/20/2017
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Queens
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? 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	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Other Child - Surviving Nephew	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Father	No Role	Male	32 Year(s)
Other Household 2	Other Adult - BM of then 2 and 4yo SSs	No Role	Male	32 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS initiated their investigation within 24 hours and diligently attempted to assess the safety of the children. ACS did not coordinate with law enforcement, and they were unable to contact the source as the source was anonymous. ACS completed a CPS history review, and notified the district attorney.

The SM was uncooperative and refused to provide any more information other than, on 3/20/17, the SC was having an asthma attack and was brought to the hospital where he stayed before succumbing to his condition. ACS interviewed the 11yo SS who reported he was little when the SC died. The 11yo SS stated he was told the SM did chest compressions on the SC. He did not provide any further information regarding the SC's death. The 9yo and 17yo both declined to be interviewed by ACS. The 18yo adult sibling was hostile toward ACS and refused to allow contact with the 1-month-old nephew.

ACS reviewed the SC's obituary. The document reflected the SC suffered from chronic and severe asthmatic and was admitted to the hospital on 3/20/17 due to complications with asthma and was subsequently pronounced deceased on 3/24/17. ACS contacted the funeral home where the SC was taken. The funeral home reported the SC passed on 3/24/17 with the cause of death being cardiac arrest status asthmatic.

The SM refused to sign releases for ACS to communicate with any providers, including the hospital, or for ACS to be able to get a copy of the death certificate. ACS was able to communicate with the SSs' schools. The Safety Assessments were completed; however, ACS was unable to fully assess the safety of the 1-month-old nephew. The Risk Assessment was completed; however, if did not reflect that some of the children had informally had other caregivers, including the 17yo SS, who at the time was residing with a relative. The progress notes were completed contemporaneously, and the case was closed on time.

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 investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: The fatality investigation was regarding the SC's death from 2017. ACS did not contact LE to determine if they were involved in 2017.

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
067388 - Deceased Child, Male, 8 Year(s)	067428 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
067388 - Deceased Child, Male, 8 Year(s)	067428 - Mother, Female, 32 Year(s)	Excessive Corporal Punishment	Unsubstantiated
067388 - Deceased Child, Male, 8 Year(s)	067428 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated

067388 - Deceased Child, Male, 8 Year(s)	067428 - Mother, Female, 32 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
067473 - Other Child - Surviving Nephew , Male, 1 Month(s)	067428 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
067473 - Other Child - Surviving Nephew , Male, 1 Month(s)	067428 - Mother, Female, 32 Year(s)	Lacerations / Bruises / Welts	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	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Law Enforcement	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?	☐	☒	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☐	☒	☐	☐
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:
ACS was unable to ask the family risk related questions due to the family being uncooperative and nonresponsive. They were unable to gather enough information to determine if the surviving sibling or 1-month-old nephew was at risk.

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:
The SC's death occurred in 2017. The SM reported the family received resources for bereavement services at that time.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The investigation took place in 2024 regarding the death of the SC in 2017. The SM reported the family received bereavement services at the time of the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The investigation took place in 2024 regarding the death of the SC in 2017. The SM reported the family received bereavement services at the time of the SC's death.

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

An investigation was opened from 8/29/13-10/24/13. The SM was substantiated for allegations of IG, LMC, and LS regarding the SC, for allegations of IG regarding the then 1yo SS and for allegations of IG, LS and LMC regarding other children.

An investigation was open from 6/3/13-6/7/13. The SM was substantiated for allegations of IF/C/S, IG, LMC, LS and PD/AM regarding the SC and substantiated for allegations of EdN, XCP, IF/C/S, IG, PD/AM, LMC and LS regarding 3 other children.

An investigation was opened from 4/29/13-5/3/13. The SM was substantiated for allegations of IF/C/S, IG, LMC, LS, and PD/AM regarding the SC and substantiated for EdN, IF/C/S, IG, PD/AM, LMC, and LS regarding 3 other children.

An investigation was opened from 4/29/13-6/27/13. The SM was substantiated for allegations of IG regarding the SC and for IG and EdN regarding 2 other children.

An investigation was opened from 2/4/11-2/7/11. The SM was substantiated for IG and IF/C/S regarding another child.

An investigation was opened from 12/30/10-2/25/11. The SM was substantiated for allegation of IG regarding the SC and 2 other children.

An investigation was opened from 10/28/10-12/30/10. The SM was substantiated for allegations of IG, IF/C/S, and PD/AM regarding the SC and 2 other children.

Preventive Services History

A preventive case was opened from 9/9/13 - 3/19/15 due to concerns for the children's hygiene, the children being underweight, the home being dirty and unkept with a lack of food, for concerns the SM was not providing appropriate medical care and for the SM possibly punching one of the children. The case was closed due to the SM no longer wanting services and her being compliant with the children’s medical appointments.

A preventive case was opened from 3/1/11-3/11/11 due to concerns the SM was exposing the children to drug use. The SM submitted to a drug test and the results were negative. The SM declined to keep preventive services open.

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