Child Fatality Report

Report Identification Number: NY-21-062

Prepared by: New York City Regional Office

Issue Date: Nov 08, 2021

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 has an open 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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 05/09/2021
Initial Date OCFS Notified: 05/09/2021

Presenting Information

According to the OCFS 7065 the the child appeared to be sick and on 5/3/21 the child lost consciousness and was admitted to the hospital where he remained until his death.

Executive Summary

This fatality report concerns the death of a five-year-old male subject child who died on 5/9/21 after a period of hospitalization beginning on 5/3/21. As of the issuance of this report the autopsy report had not been received; however, hospital staff indicated the child suffered from severe asthma and was hospitalized after a particularly severe attack.

ACS submitted the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Services Cases, as there was an open report at the time the child was hospitalized. The report alleged the mother was constantly smoking marijuana and cigarettes in the child's direct presence. A week prior to the child's death the child appeared to be sick but the mother took no action to seek medical attention. On 5/3/21 the child lost consciousness and was admitted to the hospital where he remained until his death.The information regarding the child's death was reported to OCFS under Chapter 485 of the Laws of 2006.

At the time of his death, the child resided with his mother in their shelter apartment. There were no surviving siblings or other children in the home.

ACS learned the subject child was diagnosed with asthma at age three and over the years there were episodic visits to the hospital for treatment. On 5/3/21, the subject child began to exhibit shortness of breath while he was in class for remote learning. The mother informed the teacher and then gave two treatments of the prescribed medication to the subject child. The child became unresponsive and passed out in his bedroom after the second treatment. The mother initiated CPR and called 911 for emergency medical assistance. Upon arrival, EMS transported the subject child to the hospital. The child was later transferred to the Pediatric Intensive Care Unit at another hospital.

Hospital staff reported the subject child suffered brain damage due to prolonged amount of time without oxygen, and was on life support. The hospital staff also reported the mother had acted appropriately and there were no concerns for foul play, abuse, or maltreatment. Medical staff further reported that the subject child's brain was failing and there was nothing else the medical team could do.

Following the death of the child, the mother did not make herself available any referrals for services. ACS established telephone contact with law enforcement and other collaterals. The information obtained confirmed there was no abuse or neglect regarding the care of the child.

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:
There were no allegations of DOA/Fatality regarding the death of the child. Additionally, there were no surviving siblings or children in the home. No safety or risk assessments were necessary.

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:
The level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion, was commensurate with the case circumstances.

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: 05/09/2021 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 05/03/2021
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
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 alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☒ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **Supervising child in remote class.**

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	5 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)

LDSS Response

While the child was hospitalized. ACS staff interviewed the mother and learned the SC was online for remote access schooling when he began coughing. The child began crying that he could not breathe. The mother said she interrupted the class and told the teacher she was taking the child out of remote learning as he did not feel well. The mother said she told the teacher the child would return for the afternoon session. The mother said she administered medication; however, the child's condition did not improve. The mother said the child was laying on the bed with his eyes closed and then became unresponsive. The mother initiated CPR and called EMS. Upon arrival, EMS technicians quickly took the child to the hospital. He was later transferred to another hospital for a higher level of care. During transport, the child suffered a seizure.

ACS staff made contact with the hospital where the child had been admitted. Medical personnel confirmed the child had the medical condition for a long time and that the mother acted appropriately when the child began to complain of not being able to breathe. Medical personnel said there was no suspicion of abuse or maltreatment noted.

On 5/18/21, ACS contacted the school the subject child attended. The school personnel reported the child had been engaged and there were no concerns regarding his educational needs.

On 6/10/21, after a number of failed attempts to locate the mother, the Specialist sought a legal consult regarding the possibility of filing a case against the mother. ACS's Family Court Legal Services determined that based on the fact that the mother's only child had died and there were no other known or reported children in the mother's care, ACS had no legal basis to pursue any court intervention or seek to force the mother to cooperate with the investigation. ACS's Family Court Legal Services staff also cited the fact that medical personnel reported there was no perceived negligence by the mother.

ACS determined there was no suspicion of abuse or maltreatment. As of the writing of this report, the autopsy report had not been received. No services were provided as the mother did not cooperate with ACS or make herself available for any referrals.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC region.

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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
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?	☐	☒	☐	☐

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 mother's only child died. The mother was offered bereavement counseling which she refused.							

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? N/A
Explain:
There were no surviving siblings or other children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
No services were provided as after the initial contact with ACS the mother refused to meet with ACS.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/07/2021	Deceased Child, Male, 5 Years	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 5 Years	Mother, Female, 28 Years	Internal Injuries	Unsubstantiated	
	Deceased Child, Male, 5 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SCR report alleged the 5-year-old child was diagnosed with asthma. The mother was aware of this but continued to smoke marijuana to the point of impairment around the child and while acting as the sole caregiver. As a result of the worsening asthma, the child began to suffer seizures and experienced unspecified brain damage. The report alleged the child's asthma had worsened over time but the mother did not pursue medical attention in a timely manner, creating a delay in care. Further, according to the report, on an ongoing basis the mother left the child in a urine soaked bed.

Report Determination: Unfounded | **Date of Determination:** 06/14/2021

Basis for Determination:
ACS unsubstantiated the allegations of the report on the basis of no credible evidence to support the allegations. Additionally, ACS documented the mother's only child had died; however, the child's death was not due to abuse or maltreatment.

OCFS Review Results:
ACS's response to the report was timely. ACS provided the appropriate notifications and contacted some of the appropriate collaterals which included hospital staff. ACS followed up with information. There was evidence of supervisory involvement throughout the investigation.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There was noticeable lack of contacts with collaterals during the course of the investigation. EMS was a pertinent collateral; however, case documentation did not reflect any contact to obtain any relevant information.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/21/2019	Deceased Child, Male, 3 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 3 Years	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SCR report alleged the mother was aware that her 3-year-old child had developmental delays and did not have the understanding of a typical child of that age. On 6/21/19, for unknown reasons, the mother hit the child hard in his face. It was unknown if he had any physical injuries.

Report Determination: Indicated	**Date of Determination:** 08/21/2019

Basis for Determination:
ACS substantiated the allegations od Parent's Drug/Alcohol Misuse and Inadequate Guardianship of the child by the mother on the basis of some credible evidence based on the age of the child and the mother's admission of ongoing drug use. ACS noted there was no evidence that the mother hit the child.

OCFS Review Results:
The investigation was initiated timely. Notifications of the existence and indication of the report were provided. ACS explored the allegations and incorporated the themes and patterns from prior investigations. Concerns regarding the mother hitting the child in the face were discussed and the mother was counseled against such a course of action. The child was not observed with any injury. Appropriate collateral contacts were made and there was evidence of supervisory involvement.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/20/2018	Deceased Child, Male, 2 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 2 Years	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
On 5/18/18, the two-year-old child was admitted to the hospital. On 5/19/18, the mother left the child's stroller unattended in the child's hospital room, while the child was in the crib. In the child's stroller, the mother had left her bottle of Arizona fruit punch, laced with alcohol unattended. While in the crib in the hospital room, the child was crying. Inadvertently the bottle of Arizona fruit punch was given to the child. The child then fell asleep. The child's blood alcohol level was 63 mg. No further information was known. The roles of the grandmother and the three cousins were unknown.

Report Determination: Indicated	**Date of Determination:** 07/10/2018

Basis for Determination:
ACS substantiated the allegation of Parent's Drug/ Alcohol Misuse against the mother regarding the child on the basis of some credible evidence that the conditions in the intake report existed. The mother also admitted to daily use of marijuana while caring for the two-year-old asthmatic child. ACS also substantiated the allegation of Inadequate Guardianship of the child by the mother on the basis that the mother had a clinical health concern and was not in services. The mother was using marijuana to self medicate. ACS documented the mother's drug/alcohol use while caring for the child placed the child n danger of harm, given the child's medical condition.

OCFS Review Results:
The investigation of the report was initiated timely and the appropriate collateral contacts were made. ACS obtained information from service providers and medical personnel during the course of the investigation, and the information obtained assisted in making the determination. There was evidence of supervisory involvement and appropriate notices were provided.

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

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Preventive Services History

Following the 2019 report, the mother was referred for preventive services to address drug use. The mother was compliant with services. The SC was involved in play therapy. The services case was closed on 4/1/2020.

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