Child Fatality Report

Report Identification Number: NY-22-018

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

Issue Date: Aug 29, 2022

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: 3 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 05/26/2021
Initial Date OCFS Notified: 03/22/2022

Presenting Information

An SCR report was received which alleged that on 5/21/21, the 3-year-old subject child became uncoordinated and fell down while running. On 5/22/21, the child had issues sleeping. On 5/23/21, the subject child had welts on his body as if he had been having an allergic reaction. On 5/25/21, the subject child became sick and lethargic. On 5/26/21 at 3:00AM, the subject child died as a result of acute thallium poisoning. It was unknown how the subject child was poisoned and from whom as he was in the care of both the mother and father in the week leading up to the death. Neither parent had an explanation for what happened to the child that caused his death. The grandfather had an unknown role.

Executive Summary

This fatality report concerns the death of a three-year-old male subject child that occurred on 5/26/21. A report was initially made to the SCR on that same date with allegations of Inadequate Guardianship, Lack of Medical Care, and DOA/Fatality against the child's mother. The initial investigation received on 5/26/21 was unsubstantiated due to a lack of credible evidence. New information was received as a result of the final autopsy report, and an SCR report was registered on 3/22/22 regarding the subject child's death. The New York City Administration for Children's Services (ACS) received the report and investigated the child's death.

At the time of the child's death, he resided with the mother and had regular, supervised visitation with the father. The investigation revealed that beginning on 5/18/21, the subject child had episodes of vomiting and exhibited an unsteady gait and physical imbalance. On 5/22/21, the mother took the child to his doctor, who prescribed medication and rest. Medication was administered as prescribed, and the child appeared to improve. On 5/24/21, the subject child became pale and unresponsive. The mother called 911 and the child was transported to the hospital where he died on 5/26/21. The medical examiner preliminarily determined the death was the result of a genetic disease and no foul play was noted.

On 3/22/22, ACS received the final autopsy report which revealed the subject child died as a result of acute thallium poisoning. ACS completed a thorough multidisciplinary investigation into the re-reported death upon receipt of the final autopsy toxicology results. ACS coordinated efforts with law enforcement and learned the death was being considered a homicide. At the time of this writing, the criminal investigation remained open. Law enforcement noted that no one had been ruled out as a suspect in the child's death.

ACS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, the medical examiner, and relatives. ACS provided fatality-related services to the family upon receipt of the initial report. During this investigation, the mother and father became uncooperative with ACS and requested all correspondence take place via their attorneys. ACS mailed information related to bereavement counseling to the family prior to indicating and closing their investigation.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
ACS gathered information to determine the allegations. There were no surviving siblings nor were there other children residing in the home.

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 case record reflected supervisory consultations throughout the investigation. The level of casework activity 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: 05/26/2021 **Time of Death:** 03:00 AM

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

County where fatality incident occurred: Kings
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? Yes
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? Unable to determine

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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	33 Year(s)

LDSS Response

On 3/22/22, ACS received a report regarding the death of the subject child that was previously investigated. ACS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACS established there were no siblings, nor were there any other children residing in the home where the fatal incident occurred.

ACS received the medical examiner's report on 3/21/22, which revealed the child's death was the result of acute thallium poisoning. ACS spoke with law enforcement and learned the death was being treated as a homicide and both the mother and father were suspects due to them having access to the child within the week preceding his death. The medical examiner reported the subject child was exposed to the poison more than once over the course of a week. ACS learned the maternal grandmother died several months prior to the subject child. Law enforcement exhumed the grandmother's body and ruled her death homicide as a result of acute thallium poisoning.

ACS spoke with the father via telephone and learned he was out of the state and unable to meet in person. The father informed ACS that he and the mother had a strained relationship, and he was concerned about the subject child in the days leading up to his death. The father reported he and the mother were going through court regarding custody matters and the father had limited access to the subject child. The father was able to see the child at the mother's home under her supervision. The record revealed the father last saw the subject child on 5/18/21 at a community-based agency where the father and subject child were supervised by a provider hired through the agency.

ACS exhausted efforts by making multiple telephone calls, attempting home visits, and sending certified mail to the mother. The mother refused to cooperate with ACS and requested all contact go through her attorney. The mother's attorney would not provide information to ACS and requested ACS not contact the mother due to the pending criminal trial.

ACS learned from service providers that the subject child had developmental delays and was nonverbal. The child was engaged in a community-based learning program prior to his death and was in receipt of speech, occupational, and physical therapy. The only notable concern was that the parents were going through a custody dispute and the child was to be discharged to the mother's care only. The provider had no additional concerns for the safety of the child while he attended the program.

ACS substantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother and father regarding the subject child. Due to both parents having access to the child in the week leading up to the death, it could not be

determined who poisoned the subject child. The investigation was closed as there were no surviving siblings or other children in either home. The law enforcement investigation remained open at the time of case closure.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The investigation adhered to previously approved protocols for joint investigations as New York City coordinated efforts with law enforcement and notified the DA's office of the death.

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
060175 - Deceased Child, Male, 3 Yrs	060177 - Father, Male, 33 Year(s)	DOA / Fatality	Substantiated
060175 - Deceased Child, Male, 3 Yrs	060177 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
060175 - Deceased Child, Male, 3 Yrs	060177 - Father, Male, 33 Year(s)	Poisoning / Noxious Substances	Substantiated
060175 - Deceased Child, Male, 3 Yrs	060176 - Mother, Female, 39 Year(s)	DOA / Fatality	Substantiated
060175 - Deceased Child, Male, 3 Yrs	060176 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
060175 - Deceased Child, Male, 3 Yrs	060176 - Mother, Female, 39 Year(s)	Poisoning / Noxious Substances	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?	☒	☐	☐	☐

Additional information:
The mother and father became uncooperative with ACS during this investigation and requested all contact go through attorneys. ACS exhausted efforts to interview the mother and assess her home, to no avail. The father was interviewed via phone.

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	☐	☐	☐	☐	☐	☒	☐

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 siblings nor were there other children residing in the home following the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS offered fatality-related services to the family immediately following the death. During this investigation, the parents became uncooperative thus it remained unknown whether services were being utilized. ACS sent information on bereavement counseling via mail to the mother and father.

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? No
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)
05/26/2021	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	DOA / Fatality	Unsubstantiated	No
	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
ACS received a report from the SCR concerning the death of the 3-year-old subject child that occurred on 5/26/21. The report alleged that on 5/20/21, the subject child became lethargic while in the care of the mother. It was recommended

the mother take the child for medical attention and the mother failed to do so. The child was otherwise healthy and the mother had no explanation for his death.

Report Determination: Unfounded | **Date of Determination:** 07/23/2021

Basis for Determination:
ACS determined there was no credible evidence to substantiate the allegations of DOA/Fatality, IG, and LMC of the subject child by the mother. Though the final autopsy report was not available at the time the investigation was closed, conversations with the medical examiner revealed no evidence of abuse or maltreatment and no trauma to the body. It was expected the death was the result of a medical condition the subject child was diagnosed with at 2 months old.

OCFS Review Results:
ACS completed case objectives within the required timeframes. ACS spoke with relevant collateral sources. There were no siblings or other children in the home to be assessed. ACS provided the family with the appropriate fatality related services.

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)
05/24/2021	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Internal Injuries	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 39 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
ACS received a report from the SCR on 5/24/21 alleging the subject child received two suspicious concussions while in the mother's care and the mother did not seek timely medical care. One of the concussions required on-going therapy. When the child was 9 months old, he stopped cooing and smiling. The mother waited nine months before getting the child an MRI and hearing test. On 5/21/21, the child was uncoordinated and fell while running. The mother refused to bring him for medical care. On 5/23/21, the child had welts covering his body, similar to an allergic reaction, but he had no allergies.

Report Determination: Unfounded | **Date of Determination:** 07/23/2021

Basis for Determination:
ACS determined there was no credible evidence to substantiate the allegations of IG, II, L/B/W, and LMC against the mother regarding the child. ACS found the mother provided adequate medical care for the child and medical personnel confirmed the child was up to date on immunizations and there were no concerns. On 5/22/21, the mother sought medical attention for the child as he was vomiting. The child was prescribed medication and the mother administered it as directed. The child's condition worsened and the mother called 911 on 5/24/21.

OCFS Review Results:
ACS completed case objectives within the required timeframes and provided the parents with the appropriate notice of existence letters. ACS spoke with relevant collateral contacts and documented supervisory consultation.

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 was no known CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/04/2021	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The father filed a custody petition in family court on 3/4/21 requesting custody of the subject child. Family court, on consent of both the mother and father, ordered five visits between the father and subject child.	

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