Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-066

Prepared by: New York City Regional Office

Issue Date: Dec 01, 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	

Case Information

Report Type: Child Deceased
Age: 8 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 06/01/2021
Initial Date OCFS Notified: 06/01/2021

Presenting Information

The SCR report alleged on 6/1/21, at an unknown time, while in the care of the SM and PS, the SC was found unresponsive in the home. At approximately 12:30PM, the PS brought the SC outside to access public transportation to the medical center. The SM, SC, and PS arrived at the medical center at 1:40 PM. All attempts to resuscitate the child failed and the SC was pronounced dead at 2:04PM on 6/1/21.

Executive Summary

This male subject child (SC) was 8 years old when he died in the care of his mother (SM) and the parent substitute (PS). The autopsy report had not yet been received as of the issuance of this report; however, the ME's preliminary findings indicated the SC's death was "significantly suspicious," as the SC had optic nerve hemorrhage, small subdural hemorrhages, contusion on the scalp, and small lacerations on his face and mouth. His upper left incisor tooth was chipped, and he was severely underweight. The cause and manner of death were pending.

At the time of his death, the child resided with his mother and the PS. There were no other children in the home. However, the PS has three children, ages eleven and twelve-year-old twins, who resided with their mother; he visited the children sporadically and there were no concerns. ACS assessed the children and deemed them safe with their BM in their home.

ACS' investigation revealed on 6/1/21, the SM and PS brought the child to the hospital via taxi; the SC was asystole upon arrival. The SC presented with two decubiti (bedsores), one on each side of the hip above the buttocks although the SM said he was ambulatory. The SM reported that on the morning of the incident, she left home at 7:00AM to go to work, but before leaving, she fed the SC a nutritional meal supplement (Nutrament) as he was a picky eater; however, he was not feeling well and had regurgitated. When the SM returned at 12:20 PM and checked the SC, he felt cool to the touch; therefore, she dressed him and called a taxi. The PS carried the SC to the taxi, and they arrived at the hospital at 1:40PM. The SC was pronounced dead at 2:04PM on the same day. Initially, the SM denied ever leaving the SC home alone, but later admitted she did and explained that she used "Facetime" to supervise him. The adults explained they took a taxi as they thought it would have been quicker than EMS. The SM's interview was marked with inconsistencies as she gave varying accounts.

ACS learned from LE that the SM and PS were seen leaving the home together at 7:38AM, the PS returned minutes later and did not leave until he and the SC entered the taxi. LE reported the SM and PS were planning their accounts of the incident via text. No arrests were made pending the final autopsy report.

ACS interviewed neighbors who expressed they had no major concerns regarding the care given to the SC, but noted they often heard some "light banging" coming from the apartment.

The SC's doctor reported the SC was diagnosed with Autism Spectrum disorder and seasonal allergies. He was in the 25 percentile for his weight, mobile; had no eating disorder, or swallowing problems. The SC was last examined by the pediatrician on 12/19/19 and in October 2020, he received a flu vaccine. He was up to date with his immunizations.

Prior to living in the current address, the SC was enrolled in school and was receiving appropriate services to address his needs. The school staff reported the SC had a good appetite and fed himself with utensils. He was non-verbal, ambulatory, and active. The school staff reported they had left multiple messages to transfer services for the SC, to no avail. The SM

had no explanation for the SC's lack of services since they relocated.

Following the initial interviews with the mother, ACS was unable to make successful follow up contact with the SM and PS. The PS did not respond to any questions or make himself available for an interview. Family members did not know the whereabouts of the mother following the death of the child.

On 7/30/21, ACS substantiated all allegations of the SC by the SM and PS citing ACS found credible evidence of the level of care created or allowed a substantial risk of physical injury and protracted impairment to the SC.

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:
There were no surviving siblings or children 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 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. There was documentation of supervisory consultation during the investigation.

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: 06/01/2021 **Time of Death:** 02:04 PM

Time of fatal incident, if different than time of death: 12:30 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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? Unknown if they were impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **Unknown**

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	28 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	31 Year(s)

LDSS Response

ACS initiated this investigation within the required timeframe by interviewing the hospital staff, LE, ME investigator and the SM and PS while in the presence of LE. After that initial interview, the SM and PS declined an interview despite ACS' diligent efforts.

ACS learned from the hospital staff that upon arrival, the SC's temperature was very low, he had been unresponsive longer than the SM and PS reported. He presented with signs of neglect, he weighed thirty pounds, had bed sores, optic nerve and subdural hemorrhages, contusion on his scalp, small lacerations on his face and mouth and a chipped tooth. The SM first stated she left the SC in the care of the PS's mother. The PS's mother denied having the child in her care and LE verified she had not visited. The PS denied he was at home; LE verified he was at home. The adults opted to use a taxi instead of an ambulance as they did not want to wait for an ambulance.

ACS and LE accompanied the ME investigator, to conduct a re-enactment of the incident with the SM and PS. Observed in the couples' very small bedroom within a shared apartment was a folded cot where the SC slept, and one can of nutritional

meal supplement (Nutrament).

LE reported the SM's account changed each time she recounted the incident and the SM and PS had been exchanging texts as they planned their stories. LE reported the video camera recorded the SM and the PS leaving the home together at 7:38AM. The PS returned a few minutes later and did not leave the building until the SC was carried to the taxi. LE reported the criminal investigation remained open pending the final autopsy. No arrests had been made.

The SM's family reported the SM did not disclose her whereabouts. ACS visited the PS's children and deemed them safe in the home with their mother who reported the PS made no contact with the children.

On 7/30/21, ACS substantiated the allegations DOA/fatality, CHTS, II, LABW, IFCS, LMC, IG of the SC by the SM and the PS (deemed a person legally responsible). ACS wrote that the result of their investigation found some credible evidence to substantiate the above allegations against the SM and PS who were with the SC on the day of his death.

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 investigation conducted by a Multidisciplinary Team (MDT)?Yes

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.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	Internal Injuries	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	Lacerations / Bruises / Welts	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	Lack of Medical Care	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	Lack of Supervision	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059007 - Mother, Female, 28 Year(s)	Malnutrition / Failure to Thrive	Substantiated

059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	DOA / Fatality	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	Inadequate Guardianship	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	Internal Injuries	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	Lacerations / Bruises / Welts	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	Lack of Medical Care	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	Lack of Supervision	Substantiated
059006 - Deceased Child, Male, 8 Yrs	059008 - Mother's Partner, Male, 31 Year(s)	Malnutrition / Failure to Thrive	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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 SM and PS declined to be interviewed for the duration of the investigation. Their whereabouts remained unknown.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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? No

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

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 NYS.

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