Child Fatality Report

Report Identification Number: NY-21-052

Prepared by: New York City Regional Office

Issue Date: Nov 05, 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: 12 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 05/07/2021
Initial Date OCFS Notified: 05/07/2021

Presenting Information

The SCR report alleged on 5/7/21, the twelve-year-old SC was experiencing stomach pain and a headache while under the care of the SF, paternal cousin (PC) and aunt. The SF contacted 911 and EMS responded to the case address. At that time the SC was responsive, walking and talking. Shortly after, on the way to the ER in the ambulance, the SC collapsed and went into cardiac arrest. He arrived at the hospital at 3:05 PM and was pronounced dead at 3:22 PM on the same day.

Executive Summary

The SCR registered a report that alleged this twelve-year-old SC was known as an otherwise healthy child, who resided with his SF, PC, and aunt and they had no explanation for his death. They were named subjects of the report with allegations of DOA/fatality, and IG. The SC had no siblings, and there were no other minor age children that resided in the home. The SC's mother resided out of the country. This family was not known to the SCR or ACS.

The family told the hospital staff that the SC had been involved in an altercation at school on 5/5 and 5/6/21, and he was hit in his head during the altercation. On the following day, the SC complained of abdominal pain and a headache, so he was kept home from school with the aunt, and the SF went to work. At the time of the incident, it was unknown whether the altercation contributed to the SC's death. LE initiated an investigation into the incident and reported the SC was found with no marks or bruises on his body. LE found no criminality.

ACS learned from the hospital staff that the SC had a history of vomiting and a gastrointestinal condition. The SC's pediatrician confirmed this information and noted he had been prescribed medication.

The ME listed the cause of the SC's death as peptic ulcer disease with perforation due to helicobacter pylori infection and the manner of death as natural. Initially homicide was suspected; however, it was ruled out by the ME.

The SF reported he was at work at the time of the incident and the SC was being supervised by family members. When the SF arrived home on the evening of 5/5/21, he gave the SC Tylenol and rubbed some essential oils on him before bedtime. The following day, the SC had not improved, and the family called an Uber to take the SC to the Dr, but he vehemently refused, so they called 911 for medical assistance.

ACS obtained medical records from the pediatrician and the hospital where the SC was treated a year ago. The records did not indicate the SC had an ulcer or an infection.

On 7/2/21, ACS unsubstantiated the allegations of DOA/fatality, and IG of the SC by the SF, PC and aunt citing the ME's findings. ACS found no credible evidence that the family contributed to the demise of 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?** 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

Explain:
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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:
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: 05/07/2021 **Time of Death:** 03:22 PM

Time of fatal incident, if different than time of death: 03:05 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 03:00 PM
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: **Present and alert**

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	Aunt/Uncle	Alleged Perpetrator	Female	51 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	59 Year(s)
Deceased Child's Household	Other - Paternal cousin	Alleged Perpetrator	Male	29 Year(s)

LDSS Response

This fatality concerns the death of a twelve-year-old male while in the home with his PC and aunt; the SF was at work at that time. The SCR registered three reports on 5/7/21 regarding this fatality. One was a duplicate and the other included additional information. The SCR narrative of the initial report stated that the SC had been experiencing stomach pain and a headache. The SC was responsive, walking and talking when EMS arrived at the case address at 2:37 PM. While in transit to the ER, the SC collapsed and went into cardiac arrest; he was pronounced dead at 3:22 PM.

The following SCR report stated that on 5/5 and 5/6/21, the SC was physically assaulted by multiple children at school. During the evening of the second assault, the SC was extremely lethargic, had a headache and vomited several times during the night. The report alleged that the PC and aunt were aware of the assault and illness, and they failed to seek medical attention. According to the report, on 5/7/21, at 2:08 PM the PC summoned LE and EMS to the home and upon their arrival, they observed the SC lying on a bed with a distended stomach and he was slipping in and out of consciousness. After initial treatment, the SC was able to be propped up and was asked what happened and he responded, “I was either punched or hit in the head”; he then became unconscious in the ambulance.

The ACS Field Office initiated the investigation within the required timeframe. ACS contacted and interviewed LE, hospital staff, ME, family, and school staff in addition to retrieving medical records for the SC.

ACS learned from LE that the attending Dr found no visible signs of abuse on the SC and that homicide was ruled out. The ME listed the cause of death as peptic ulcer disease with perforation due to helicobacter pylori infection and the manner as natural. The ME explained that “the bacteria that leads to the peptic ulcer disease is common, but when left untreated for an extended period can cause ulcers and inflammation.”

ACS obtained the SC’s medical records from the hospital and the primary care physician that reflected the SC was seen in the ER on 5/29/20 for persistent heartburn and vomiting that had persisted a few months prior. The SC was prescribed medication, advised to avoid certain foods, and to follow up with a pediatric gastroenterologist if symptoms persisted. According to the PC, due to the current pandemic, the pediatrician’s office was closed. The SC was up to date with immunizations.

The school staff reported the SC was talkative, and well liked and he was not bullied. He was often in the nurse's office and often absent due to illness.

According to the family, on the evening of 5/6/21 and 5/7/21, the SC was given Tylenol and Dayquil and the PC attempted several times to take the SC to the hospital, but he refused. As the SC became more lethargic, the PC called 911 for emergency medical assistance. The family declined services.

On 7/2/21, ACS unsubstantiated allegations of DOA/fatality and IG of the SC by the SF, PC, and aunt. ACS cited the ME's findings and stated they found no credible evidence that the family contributed to the demise of the SC.

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: 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
058561 - Deceased Child, Male, 12 Yrs	058562 - Father, Male, 59 Year(s)	DOA / Fatality	Unsubstantiated
058561 - Deceased Child, Male, 12 Yrs	058562 - Father, Male, 59 Year(s)	Inadequate Guardianship	Unsubstantiated
058561 - Deceased Child, Male, 12 Yrs	058563 - Other - Paternal cousin, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
058561 - Deceased Child, Male, 12 Yrs	058563 - Other - Paternal cousin, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
058561 - Deceased Child, Male, 12 Yrs	058564 - Aunt/Uncle, Female, 51 Year(s)	DOA / Fatality	Unsubstantiated
058561 - Deceased Child, Male, 12 Yrs	058564 - Aunt/Uncle, Female, 51 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?	☒	☐	☐	☐
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 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 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:
The family declined services.

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