Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-038

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

Issue Date: Jul 31, 2023

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 04/06/2023
Initial Date OCFS Notified: 04/07/2023

Presenting Information

The Administration for Children's Services (ACS) received an SCR report which alleged that on 04/06/2023 at approximately 1:45AM, the 4-year-old subject child woke up from sleeping and vomited blood. The mother attempted to change the child's clothing and noticed her going in and out of consciousness and then called 911. Law enforcement and emergency services responded and transported the child to the hospital where she was pronounced deceased at 2:53AM. The child was an otherwise healthy child and there was no explanation for her death.

Executive Summary

This fatality report concerns the death of a 4-year-old female subject child that occurred on 4/6/2023. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the subject mother regarding the subject child. At the time of her death, the subject child resided with the subject mother. There were no surviving siblings. The subject mother and biological father had prior CPS history.

ACS collaborated investigative efforts with law enforcement and learned that on 4/5/2023, the subject mother put the subject child to bed at 8:00PM. The subject mother then checked on the subject child at approximately 1:45AM on 4/6/2023 and noticed the subject child had vomited what appeared to be blood. The subject mother attempted to change the subject child’s clothes, noticed she appeared to be sleeping, and then called 911. Law enforcement and emergency medical services (EMS) arrived and started lifesaving measures. The subject child was transported to the hospital where lifesaving measures continued; however, were unsuccessful. The subject child was pronounced deceased at 2:53AM.

An autopsy was performed; however, the final autopsy report was not completed at the time this report was written. Preliminary findings from the medical examiner revealed the subject child had an enlarged liver; however, it was unknown if that contributed to the child’s death. The medical examiner noted no evidence of abuse or neglect. Law Enforcement did conduct a criminal investigation; however, the record did not reflect an update on their investigation at the time this report was written.

ACS unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the subject mother. ACS determined that there was no evidence of abuse or neglect by the subject mother and the child's needs had been met. The CPS investigation was unfounded and closed on 6/6/2023.

ACS offered the subject mother bereavement services and burial assistance. The record did not reflect the child's correct date of birth was entered into CONNECTIONS or that diligent efforts were made to contact the subject child's birth father.

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:**
  - **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

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 detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The subject child's date of birth was left as estimated and never updated in CONNECTIONS. The CONNECTIONS record included a note regarding an unrelated CPS investigation involving a different family.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is related, relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	ACS did not document diligent efforts to locate the BF and address the report with him.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/06/2023 **Time of Death:** 02:53 AM

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 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	Female	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)

LDSS Response

Upon receipt of the SCR report on 4/7/2023, ACS initiated their response within 24 hours and coordinated their investigation with law enforcement. ACS spoke with collateral sources, completed a history check regarding the family, and informed the district attorney's office regarding the fatality. There were multiple attempted home visits conducted. There were no surviving siblings.

ACS interviewed the SM at the MGM's home and learned that on 4/5/2023, the SM put the SC to sleep at approximately 8:00PM in the SM's bed and left the door to the bedroom open while the SM watched TV in the living room. On 4/6/2023 at approximately 1:45AM, the SM heard the SC making strange moaning noises. The SM went to check on the SC and found that the SC had vomited. The SM asked the child if she had thrown up and the SC made a nodding gesture of yes. The SM noticed the vomit appeared to be blood. The SM attempted to change the SC's clothing and noticed the SC was unusually lethargic and appeared to be asleep. The SM then called 911 at approximately 1:50AM and was instructed not to do CPR. EMS and law enforcement arrived at the home, noted the SC had a very light pulse and began CPR on the child. The SC was taken down the stairs while EMS continued CPR and put into an ambulance to be transported to the hospital. The SM went into another ambulance that met the SC at the hospital. Medical staff continued lifesaving measures at the hospital; however, were unsuccessful and the SC was pronounced deceased at 2:53AM. The record did not reflect that there were diligent efforts made to contact the BF regarding the death of the SC.

ACS learned through records and interviews that the SC was not feeling well days before she died. The SC and SM went to a church retreat from 4/1/2023-4/2/2023 and on the way home the SC was eating cheese doodles and vomited in the car. The SM reported that she thought the SC was experiencing car sickness. The SC continued to not feel well on 4/3/2023 and did not have an appetite for two days, the SM reported she gave the SC Tylenol during that time. On Wednesday 4/5/2023, the SC was reported to have been feeling a little better and the SM took the SC to the park at approximately 11:00AM where the SC played and sat on a park bench. Later that same day the SC ate some food and sat on the couch to watch cartoons with the SM before being put to bed at 8:00PM.

ACS attempted to contact the ME the day the CPS investigation was closed; however, were unsuccessful. The autopsy was still pending at the time this report was written and there were no further updates beyond the initial findings of an enlarged liver and no evidence of abuse or neglect. Toxicology results were pending. The SC had been seen by her pediatrician on 3/8/2023 prior to her death where she received her 4-year immunizations. The primary pediatrician reported the SC did not have any known medical conditions or concerns other than the enlarged liver that was discovered during the autopsy. The child was said to have been a healthy child who had been seen for routine medical care on a consistent basis.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063451 - Deceased Child, Female, 4 Yrs	063452 - Mother, Female, 27 Year(s)	DOA / Fatality	Pending
063451 - Deceased Child, Female, 4 Yrs	063452 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Pending

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:
ACS documented several attempts to conduct a home visit when the investigation was initiated. The record did not reflect that there were diligent efforts made to locate and interview the BF.

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.

Have any Orders of Protection been issued? No

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	☐	☐	☐	☐	☐	☒	☐

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/05/2021	Deceased Child, Female, 2 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 2 Years	Mother's Partner, Male, 27 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report dated 4/5/2021 alleged the mother and parent substitute had a history of engaging in mutual altercations in the presence of the subject child.

Report Determination: Indicated **Date of Determination:** 06/04/2021

Basis for Determination:
ACS interviewed the mother and the parent substitute who confirmed there was an altercation between them in the presence of the subject child. ACS obtained surveillance video of the parent substitute striking the mother and the subject child was present and appeared scared. The mother obtained an OP against the parent substitute and there had been no known contact between them since.

OCFS Review Results:
ACS conducted multiple home visits and interviews with the mother. The mother was referred to mental health counseling by ACS and accepted. The subject child was observed, and no concerns were documented. ACS contacted collaterals but did not attempt to contact the biological father of subject child.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
The parent substitute who was a subject of the report, was interviewed over the phone and not face to face on 6/2/2021.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Case record contains information that is relevant, useful, factual and objective
Summary:
The subject child's date of birth was left as estimated and not updated in CONNECTIONS.
Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:
ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/22/2020	Deceased Child, Female, 1 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report dated 5/22/2020 alleged the mother had unspecified mental health concerns. The mother was aggressive and verbally threatening towards other adults in the presence of the subject child. The home was in disarray due to the mother throwing things in the presence of the subject child. The mother was actively hallucinating and yelling at people and things that were not present.

Report Determination: Unfounded | **Date of Determination:** 07/21/2020

Basis for Determination:
ACS interviewed the mother who denied having mental health concerns. The subject child was observed and presented well taken care of. Collaterals were contacted who did not provide any further supporting evidence. The home was assessed multiple times and presented clean and organized. The mother was observed being able to care for the subject child.

OCFS Review Results:
ACS observed the home to be appropriate and meeting a minimal degree of care. The subject child was observed to be clean and well without marks, bruising or diaper rashes. The mother had an active stay away order of protection in place against the subject child's father due to domestic violence. Contact with the birth father was attempted but not successful. The mother denied mental health concerns and presented appropriate to care for child.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
ACS did not interview the BF or notify him of the investigation. ACS was made aware the BF was incarcerated on 6/25/2020; however, diligent efforts to interview him were not made. Notification letters to the SM and BF were generated on 7/31/2020 after the investigation was closed on 7/20/2020.
Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(a)

Action:

ACS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:

Case record contains information that is relevant, useful, factual and objective

Summary:

The subject child's date of birth was left as estimated and never updated in CONNECTIONS.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

[redacted]

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.

Preventive Services History

ACS opened a Family Services Stage (FSS) to conduct a legal consult to determine if a neglect petition should be filed or if additional services needed to be offered. It was decided that the family was being compliant with the order of protection in place against the parent substitute and there was no basis for filing a neglect or offering additional services. ACS reminded the mother of the domestic violence community services that were available to her and the importance of taking care of any mental health concerns. No FASPS were completed. The FSS was open on 6/7/2021 and closed on 7/6/2021.

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

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown

Explain:

The subject mother's partner was arrested and issued an order of protection to stay away from the subject mother and subject child due to domestic violence that occurred in the presence of the child on 04/05/2021.

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