Child Fatality Report

Report Identification Number: NY-23-059

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

Issue Date: Nov 27, 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: 9 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 06/02/2023
Initial Date OCFS Notified: 06/02/2023

Presenting Information

The Administration for Children's Services (ACS) completed an OCFS-7065 Agency Reporting Form on 6/6/2023, after learning of the 9-year-old female child's death which occurred on 6/2/2023. The form reflected that the subject child died from complications of a possible viral infection and a diagnosis of DiGeorge Syndrome. There was an open preventive services case at the time of the fatality.

Executive Summary

This fatality report concerns the death of a 9-year-old female child. ACS learned of the child's death that occurred on 06/02/2023. The fatality occurred during an open preventive services case that was initiated on 03/09/2016 after the child was admitted to the hospital as a result of many missed medical appointments. At the time of her death, the child had been diagnosed since birth with DiGeorge Syndrome which was a genetic disorder caused by the deletion of a portion of chromosome 22. This disorder can cause heart defects, learning and developmental issues and impact the body's immune system. The child's health had to be closely monitored by medical professionals. The child was born at seven months gestation with a medical condition and underwent heart surgery approximately two weeks later. At the time of her death, the child resided with her mother, grandmother, 6-month-old surviving sibling, 13-year-old maternal aunt, 18-year-old maternal uncle, and 21-year-old maternal uncle. The birth father did not live in the home or have frequent contact with the child. The surviving sibling and the maternal aunt were assessed as safe in the care of the mother and grandmother. The family had prior CPS history.

Upon becoming aware of the child's death, ACS and the contract agency providing the preventive services, made several visits to the case address to provide emotional support and fatality-related services to the family. ACS completed collateral and casework contacts and learned that the child had, what appeared to be, a stomach illness the day before her death which caused a loss of appetite and vomiting. The mother explained the child's symptoms had improved the morning of the fatal incident. On 06/02/2023 the child was put down for a nap at approximately 12:30PM. A short time later the child was found unresponsive by her mother. 911 was contacted and the mother started CPR. Emergency medical services arrived and took over lifesaving measures. The child was transported to the hospital where she was pronounced deceased.

An Autopsy was performed; however, the final autopsy report had not been received at the time this report was written. Law enforcement conducted an investigation and declined to pursue any criminal charges. ACS offered the family services in relation to the death of the child. The preventive service case remained open at the time this report was written.

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?** 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 was not an SCR report regarding the fatality therefore safety and risk assessments were not required; however, ACS documented an assessment of the SS and the 13yo MA's safety following the death and there were no concerns. ACS and the contract agency made multiple face-to-face contacts with the family, specifically the BM to ensure her wellbeing after the child died.

Was the decision to close the case appropriate? N/A
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 decisions surrounding this case were made commensurate with the case circumstances; however, ACS did not complete a plan amendment after the SC died. The preventive services case remained open at the time this report was written to provide services for the surviving sibling.

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: 06/02/2023 **Time of Death:** 04:18 PM

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? No
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	Aunt/Uncle	No Role	Male	18 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	21 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	13 Year(s)
Deceased Child's Household	Deceased Child	No Role	Female	9 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	51 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Month(s)

LDSS Response

At the time of the fatality, the family was involved in an open preventive services case that initiated on 03/09/2016. The preventive services case was opened to support the mother's compliance, attendance, and scheduling of the child's many medical appointments. The child had been diagnosed with a genetic disorder called DiGeorge Syndrome shortly after birth. The child had been hospitalized before the preventive services case opened due to abnormal laboratory results that would have been appropriately monitored if she had attended all her medical appointments. Since the opening of the preventive services case, the mother had been receiving support and was closely monitored to ensure that the child attended her medical appointments. ACS was informed on 06/02/2023 the child became unresponsive at home and then later died at the hospital on the same day.

During the open preventive services case, the record reflected the child, and the 6-month-old (6mo) SS were seen at least twice monthly. There was consistent casework contact with the family up until the child's death. After learning of the child's death, ACS and the contract agency immediately offered emotional support and fatality-related services to all members of the family. ACS learned the child had not felt well, did not have an appetite, and had vomited the day before her death. The mother reported the child's symptoms had improved by the next morning. The mother kept the child home from school that day to ensure she was comfortable and recovered. The child had been tired the afternoon of her death, so she laid down for a nap at approximately 12:30PM. The mother checked on the child at approximately 1:00PM and found the child with her hand over her nose, her bottom lip dark blue, and unresponsive. The mother reported that the child had vomit near her face. The mother immediately called to the 21yo MU to help carry the child to the bathroom to splash water on her face to try and wake her up. When the child did not wake up, the mother called 911 and started CPR with the assistance of the 21yo MU. EMS arrived a short time later and the child did not have a pulse. EMS took over lifesaving measures and transported the child to the hospital where she was pronounced deceased.

ACS contacted the ME who reported it was suspected the child had died of natural causes; however, the final autopsy was still pending at the time this report was written. Preliminary findings did not show signs of abuse or neglect. ACS learned that the mother was appropriate in her care of the child and medical collaterals reported no concerns for the care provided

by the mother. LE reported that there were no charges filed, they did not suspect foul play, and they would be closing their investigation.

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 referred to an OCFS approved Child Fatality Review Team? No

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?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☐	☒	☐
At 7 days?	☐	☐	☒	☐
At 30 days?	☐	☐	☒	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐
Explain: There was not an SCR report regarding the fatality therefore safety assessments were not required; however, ACS documented an assessment of the SS and 13yo MA's safety following the death and there were no concerns.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☒	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: There was not an SCR report regarding the fatality therefore a risk assessment for the fatality was not needed. The family was receiving preventive services for the child and the 6mo SS at the time of the fatality and risk was continually being monitored throughout the services case. The family continued to receive services after the child's death.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☐	☒	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐
Explain as necessary: No children had to be removed as a result of this fatality.				

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? No
Explain:
Service needs in response to the fatality were not identified for the 6mo SS or 13yo MA.

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)	Status/Outcome	Compliance Issue(s)

11/17/2022	Sibling, Female, 2 Months	Mother, Female, 29 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 2 Months	Mother, Female, 29 Years	Lack of Medical Care	Far-Closed	

Report Summary:
A FAR report dated 11/17/2022, alleged the mother was failing to ensure that the then 2-month-old (2mo) SS was being fed properly. The then 2mo SS suffered from a medical disorder that required medical equipment to avoid severe vomiting and choking. The medical equipment broke, and the mother bottle fed the then 2mo SS. The mother was advised to take the then 2mo SS to the pediatrician or the ER to avoid any medical issues. The child had no role.

OCFS Review Results:
ACS made contact with the family and medical providers and learned that then 2mo SS was routinely seen by doctors and specialists. The mother was using the medical equipment as directed and there were no further concerns for the then 2mo SS. Safe sleep was discussed and communicated multiple times during the open case.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
ACS documented the names of the BFs; however, the record did not reflect ACS made diligent efforts to interview or address the FAR report with them.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
ACS will make casework contacts per 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 birth mother and aunt’s dates of birth were 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/14/2021	Deceased Child, Female, 8 Years	Mother, Female, 28 Years	Inadequate Guardianship	Far-Closed	Yes

Report Summary:
An FAR report dated 7/21/2023, alleged the mother failed to ensure that the child attended school. The child had an IEP and was missing needed services when she was not in school. The child missed approximately 50% of the school year.

OCFS Review Results:
ACS made contact with the family and multiple collateral contacts. ACS verified that the child was attending her medical appointments and that she was attending school on a regular basis. ACS attempted several times to set up a meeting between the mother and the school; however, were unsuccessful in getting the school to make time to meet with the

family. At case closure, the record reflected the school stating there was no need to meet with the family in person as the child's attendance had improved.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
ACS documented the name of the BF within progress notes; however, the record did not reflect that ACS made diligent efforts to contact him or address the FAR report with him.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
ACS will make casework contacts per 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 birth mother'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.

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

There were four CPS investigations between 9/27/2013 to 2/1/2018. One report was unfounded for IG and LMC against the mother for the child. This case was closed, and a voluntary preventive services case opened to support the mother in making and attending medical appointments for the child. The three other investigations were indicated. One report was indicated against the child's BF for IG related to domestic violence against the mother and the child getting hit during a domestic incident initiated by the BF. The two remaining investigations were indicated for IG and LMC against the mother for not ensuring the child attended her medical appointments.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 03/09/2016

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine

Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Preventive services were provided by a contracted agency.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Failure to Complete a Plan Amendment
Summary:	ACS failed to document a plan amendment when the child, who was receiving preventive services, died.
Legal Reference:	18 NYCRR 428.7
Action:	The contract agency will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. This will be done within 30 days of the change if an initial FASP has already been completed unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

A preventive services case opened in March 2016, as a result of an unfounded CPS investigation regarding the BM was not taking the SC to her medical appointments that monitored her DiGeorge Syndrome. The SC was admitted to the hospital as a result of missed medical appointments. The contracted preventive services worked with the family from 2016 to the present time. The 6mo SS was added to the services case at birth due to receiving the same medical diagnosis that the SC had. The services providers were attentive to the family's needs.

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