



Report Identification Number: NY-21-127

Prepared by: New York City Regional Office

Issue Date: May 24, 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	



Case Information

Report Type: Child Deceased
Age: 6 year(s)

Jurisdiction: Bronx
Gender: Male

Date of Death: 11/25/2021
Initial Date OCFS Notified: 11/25/2021

Presenting Information

The SCR report alleged on 11/24/21, the SC presented as ill and was vomiting throughout the day. The BM provided the SC with smoothies to supply him with nutrients but did not seek out any medical care. On the evening of that same day, the SC presented as lethargic and fatigued. The BM decided to transport the SC from an area hospital to another hospital outside of New York City. This delayed the SC from receiving the needed medical care. Upon arrival at the hospital, the SC did not have any pulse. The hospital staff found the SC to be severely dehydrated with high potassium levels and appeared to have been vomiting blood. The SC was later pronounced dead by hospital staff at 1:45AM on 11/25/21. There were concerns that the delay in medical treatment may have led to the SC's demise.

Executive Summary

The 6-year-old male SC died on 11/25/21. According to the ME, the cause of death was infarcted small bowel and intestinal obstruction due to internal pericecal herniation of the ileum. The manner of death was natural.

At the time of the incident the SC resided with his biological parents. There were no surviving siblings or other children in the home.

On 11/25/21, ACS initiated the CPS investigation in a timely manner, and the case documentation reflected at about 4:30PM on 11/24/21, the SC did not feel well as he vomited and was lethargic. The parents sought medical attention for the SC at a nearby hospital where he was born. The parents felt the hospital was not attending to the SC in a timely fashion, therefore they took the SC to another hospital located about 15 minutes away from New York City. During transport to the hospital, the SC's condition worsened. He arrived at the hospital in cardiac arrest and became unresponsive. The medical team unsuccessfully worked to revive the SC prior to pronouncing him dead.

ACS contacted the hospital staff, medical provider, school staff, LE, ME, family, relatives, neighbors, and other key collaterals regarding the cause and circumstances of the SC's death. No one reported any concerns about the parents' care. The parents and family members denied the SC displayed any concerning behavior prior to his death. The hospital staff and the ME denied the SC had any marks or bruises on his body. LE did not suspect any criminality and closed the criminal investigation.

On 1/24/2022, ACS unsubstantiated the allegations of the report due to lack of credible evidence. ACS supported the decision with information from the autopsy report. ACS also documented there was no evidence that the parents acted inappropriately when they decided to transport the SC from an area hospital to another hospital located minutes away from New York City.

The family declined bereavement services; however, ACS kept the FSS case open to reimburse the family for the funeral expenses.

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? 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:
The parents did not have any other children in their care; however, ACS kept the FSS case open to reimburse the family for the funeral expenses.

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: 11/25/2021

Time of Death: 01:45 AM

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: Fell ill

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: **Not Applicable**

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	6 Year(s)
Deceased Child's Household	Father	No Role	Male	53 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	49 Year(s)

LDSS Response

On 11/25/21, the hospital staff reported the SC arrived at the hospital in cardiac arrest and without a pulse. The medical team tried to revive the SC but were unsuccessful; the SC was then pronounced him deceased.

On 11/25/21, the DA and the CPS staff of the county where the SC passed provided very limited information about the fatality. They reported the family did not have any history in their county. The DA stated the case would be transferred to the jurisdiction of the family's case address.

On 11/25/21, the LE stated based on the ME's findings, there was no criminality involved and the criminal investigation was closed.

On 11/25/21, ACS visited the family at the case address. The BM provided an account of events prior to the incident which were the same as reported in the intake narrative. She stated the SC was a healthy, active, and happy child. Besides being autistic, the SC did not have any other medical diagnoses. The BF refused to be interviewed by ACS, stating he was mourning his son's death. The family's neighbors and a relative did not report any concerns for the family.

On 11/25/21, the ME reported the SC passed away from a very rare condition called infarcted small bowel and intestinal obstruction due to internal pericecal herniation of the ileum. The SC's small intestines were twisted and that had caused a significant segment of his bowel to become swollen and leaky. The SC was non-verbal Autistic and not able to communicate his distress. The ME did not find any indication that the SC had any congenital abnormalities, (medical issues he was born with), prior surgery, or any marks or bruising that would indicate abuse or neglect.

On 11/26/21, ACS visited the case address. The BF agreed to an interview by ACS but did not provide any new information about the incident. The family was receptive to ACS' offer of counseling services. The BM signed the Health Insurance Portability and Accountability Act form for the release of the SC's medical records.

On 12/1/21, ACS made contact with the BM. She reported the family was coping with their loss. ACS informed the family that there were services available they could utilize. The BM thanked ACS for the offer.

On 12/9/21, the school staff did not report any concerns for the family. The parents were attentive and available when needed. The school had raised funds towards the SC's funeral to support the family.

On 12/9/21, the pediatrician confirmed the child's diagnosis , but stated the SC did not have any other known medical



condition. He was last seen on 7/22/21 for a note to be able to return to school.

On 12/10/21 and 12/15/21, ACS assisted the family with funeral expenses. The family was offered bereavement services; however, they declined

On 12/15/21, the hospital staff stated there were no signs of abuse to the SC upon arrival at the hospital on the day of the incident.

On 1/24/22, ACS unsubstantiated the allegations of the report. The family declined bereavement counseling services.

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 referred to an OCFS approved Child Fatality Review Team? No

Comments: There is no OCFS approved Child Fatality Review Team in New York City.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060514 - Deceased Child, Male, 6 Yrs	060515 - Mother, Female, 49 Year(s)	DOA / Fatality	Unsubstantiated
060514 - Deceased Child, Male, 6 Yrs	060515 - Mother, Female, 49 Year(s)	Inadequate Guardianship	Unsubstantiated
060514 - Deceased Child, Male, 6 Yrs	060515 - Mother, Female, 49 Year(s)	Lack of Medical Care	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

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?** No
- 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

The family did not have any 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? 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