Child Fatality Report

Report Identification Number: NY-23-076

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

Issue Date: Dec 11, 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: 17 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 08/09/2023
Initial Date OCFS Notified: 08/09/2023

Presenting Information

The Administration for Children's Services (ACS) completed an OCFS-7065 Agency Reporting Form on 8/9/2023 after learning of the 17-year-old female child's death which occurred on that day. The form reflected that the child had consumed fentanyl and was in a coma for approximately 6 days before a brain-death test was performed and confirmed the child was clinically deceased. There was an open CPS investigation at the time of the fatality.

Executive Summary

This fatality report concerns the death of a 17-year-old female child. ACS learned of the child's death the same day it occurred, 8/9/2023. The fatality occurred during an open CPS investigation that was initiated on 8/7/2023 after the child was brought to the hospital unresponsive by a friend. The CPS investigation contained allegations of Inadequate Guardianship and Poisoning/Noxious Substance against the mother for the child having fentanyl in her system. At the time of her death, the child resided with her mother, 15-year-old sibling, and 4-year-old sibling. The father did not live in the home but did have frequent contact with the children. The surviving siblings were assessed to be safe in the care of the mother. The family had prior CPS history.

Upon becoming aware of the child's death, ACS completed collateral and casework contacts and learned that the child had left the home with a 30-year-old friend on 8/3/2023 after the mother had denied her request for permission to go with that friend. The child was with the 30-year-old friend for approximately 2 hours when the friend noticed the child was unresponsive in the front seat of his car. The friend stated he thought she was sleeping and did not seek help immediately. The child's breathing became noticeably different after about an hour and at that time the friend took the child to the emergency room. The child had been gone from the home for approximately 3 hours when the 15-year-old sibling received a text message from a female friend of the deceased child, stating the child was in the hospital and in critical condition. The mother went to the hospital immediately and was advised that the deceased child had consumed fentanyl and she had been without oxygen for approximately one hour, causing a traumatic brain injury. ACS learned that the mother did not want the child to go out with the 30-year-old friend as she had heard he was dangerous and had fled another country due to gang activity. The child never regained consciousness and remained in a coma until 8/9/2023 when she was declared clinically deceased after a brain-death test confirmed there was no brain activity. The family made the decision to remove the child from life-support on 8/10/2023.

There was no autopsy performed as medical professionals knew how the child died; however, the official cause and manner of death had not been declared at the time this report was written. Law enforcement conducted an investigation that remained open at the time this report was written; however, the family was ruled out as having anything to do with the deceased child's death. The CPS investigation remained open at the time this report was written.

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:
This was not an SCR reported fatality, the safety assessment tool and determination were not required; however, ACS did assess the sibling's safety.

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. The case remained open at the time this report was written.

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: 08/09/2023 **Time of Death:** 01:12 PM

Date of fatal incident, if different than date of death: 08/03/2023
Time of fatal incident, if different than time of death: 05:30 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 and/or ingested alcohol or drugs? Yes
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	No Role	Female	17 Year(s)
Deceased Child's Household	Mother	No Role	Female	41 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)

LDSS Response

At the time of the fatality, the family was involved in an open CPS investigation, initiated on 8/4/2023. The investigation was regarding concerns that the mother had left fentanyl accessible to the children and the 17-year-old child consumed it and as a result had to go to the hospital and was in a coma. ACS was consistently in contact with the family from the start of the CPS investigation and learned on 8/9/2023 the child was declared clinically deceased after a brain-death test showed no brain activity.

During the open CPS investigation, ACS contacted the family, collateral contacts and interviewed and observed the surviving siblings. ACS learned of the SC's expected death the day it occurred. ACS learned that the SC was with a 30-year-old other adult (OA1) friend at approximately 3:30 PM on 8/3/2023 against the mother's wishes. The OA1 had picked the child up at her residence where surveillance showed the SC appearing happy and acting her normal self, prior to getting into his car. The SC was with the OA1 for approximately 2 hours before the OA1 reported the SC stated she felt unwell and fell asleep in the front passenger seat of his car. During those two hours, the OA1 had picked up another friend (OA2) who was seated in the back seat. When the two men saw the SC was sleeping, they attempted to splash water on her face to wake her up. The OA2 recorded a video of the OA1 attempting to wake the SC who presented as unresponsive. The OA1 then noticed the SC had shallow breathing. The OA1 took the OA2 back to his residence and then headed towards the hospital. There was approximately 45 minutes to one hour of time between when the OA1 noticed the irregular breathing and the time the SC arrived at the hospital. The OA1 arranged for the mother to get to the hospital and then left when she arrived. Interviews with the OA1 revealed, he denied giving any drugs to the SC; however, the record reflected law enforcement recovered text messages from the OA1's cellphone to another individual stating that he did give her a substance while she was in his car. ACS learned through medical collaterals the SC had tested positive for fentanyl and was in a coma. The SC remained in a coma until she was declared clinically deceased on 8/9/2023 and then taken off life-support the next day, 8/10/2023.

The record reflected the law enforcement investigation was ongoing, but it was unlikely that charges would be filed against anyone as the evidence collected suggested the SC had willingly consumed the fentanyl. The record reflected the family members were not suspects in the death.

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 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?	☐	☒	☐	☐
School	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The record did not reflect the SC's school was contacted by ACS. Information gathered by this collateral could have been helpful in determining whether there were concerns related to the SC.

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 SSs 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	☒	☐	☐	☐

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 needed 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? Yes
Explain:
ACS referred the 15yo SS and the 4yo SS to bereavement and mental health services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided fatality-related services to all family members who lived with or had close contact with the deceased child.

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? No

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)
08/07/2023	Deceased Child, Female, 17 Years	Mother, Female, 41 Years	Inadequate Guardianship	Pending	Yes
	Deceased Child, Female, 17 Years	Mother, Female, 41 Years	Poisoning / Noxious Substances	Pending	
Report Summary:					

An SCR report dated 8/7/2023 alleged the 17yo subject child was able to access fentanyl that was left accessible in the home by the mother. The SC suffered a cardiac arrest from the drug and was brought to the hospital. The SC received multiple doses of Narcan; however, it was determined that she was without oxygen for a prolonged period of time causing her organs to shut down resulting in the SC going into a coma. The SC remained in a coma.

Report Determination: Undetermined

OCFS Review Results:
ACS made contact with the family, medical providers and other collateral contacts and learned on 8/3/2023 the child asked the BM for permission to go out with her friend and the BM denied her request. The SC disregarded the BM's directive and secretly left the home. The SC was picked up from her home by the OA1. While in his car the SC became unconscious and unresponsive. The OA1 drove the SC to a hospital and then left a short time later. Hospital records revealed the SC had fentanyl in her system and after several tests the SC was declared brain-dead. The parents made the decision to end life support on 8/10/2023. ACS learned the child was not a drug user and the parents had no history or knowledge of any drug use occurring. ACS contacted LE who stated the OA1 had sent text messages stating that he gave the SC a substance. ACS assessed the safety of the SSs who were safe in the care of the BM and BF. An additional information report was made subsequent to the CPS investigation when the SC died and an OCFS 7065 Reporting Form was completed. ACS investigated the circumstances surrounding the SC's death and determined her death was not caused by abuse or maltreatment by the mother.

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:
ACS did not update the DOB of the 4yo SS in CONNECTIONS, the DOB was left as estimated. PIDS were not merged for the BM and BF where more history was found following a name search.

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.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
ACS did not accurately answer the risk elements related to domestic violence and a child in the care of a substitute caregiver. Both parents had a history of domestic violence, and the SC was living out of the country with family until 12/2022.

Legal Reference:
18 NYCRR 432.2(d)

Action:
ACS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACS failed to contact the local CPS where the child resided for most of her life prior to coming to live in NY.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:

ACS will make diligent efforts to contact collaterals to potentially gather outside information.

[redacted]

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

The record reflected one indicated CPS investigation and two FAR cases from 11/15/2016 through 5/8/2020. The concerns in the CPS investigation were EdN and IG against the BM and BF regarding the now 15yo SS. The SS had not gone to school at all in 2016 at the time the report was called in due to an issue with proof of residency. There was domestic violence in the home in the presence of the now 15yo SS and as a result the BF was arrested, and a temporary order of protection was put in place. The case was open to a family service stage for preventive services. Two FAR cases had concerns for EdN and IG regarding the now 15yo SS and now 4yo SS related to not having food in the home and the now 15yo SS not attending school and missing IEP services.

Preventive Services History

The record reflected there was a history of two, family service stages (FSS) for preventive services. The first FSS was open from 12/22/2016-8/16/2018 as a result of an indicated CPS investigation. The FSS was open due to concerns for educational neglect and domestic violence in the home. All goals were achieved when this stage was closed. The second FSS was open 6/23/20-4/26/21 due to job loss and unstable housing. The BM was opened to public assistance benefits and housing assistance. There was consistent casework for the first two months of this FSS and then a 6-month gap with no casework and then the case was abruptly closed citing that services were no longer needed.

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