Child Fatality Report

Report Identification Number: NY-23-079

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

Issue Date: Feb 09, 2024

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		

Case Information

Report Type: Child Deceased
Age: 11 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 08/19/2023
Initial Date OCFS Notified: 08/21/2023

Presenting Information

The 11-year-old child (SC) passed away during an open investigation while in the care of her mother (BM), maternal aunt (MA), and maternal grandmother (MGM) on 8/19/2023. An SCR report was made on 7/25/2023 with concerns the mother left the child in the care of the maternal aunt and grandmother without her prescribed medications while she was out of the country with the 6-year-old sibling and 4-month-old sibling. The 11-year-old child was hospitalized on 7/20/2023, after experiencing a high fever and seizure. The child was discharged to home from the hospital on 8/15/2023. On 8/18/2023, the child spiked a fever and the mother called 911 to transport the child to the hospital. The child became unresponsive in the ambulance and was pronounced dead upon arrival to the hospital.

Executive Summary

This report concerns the death of an 11-year-old child which occurred while in the care of her mother, aunt, and grandmother. The child had been hospitalized for sepsis and methicillin-resistant Staphylococcus aureus (MRSA) from 7/20/2023-8/15/2023. The child was also diagnosed with other developmental disabilities since birth which included epileptic encephalopathy, cerebral palsy, global developmental disabilities, chronic lung disease type 2 heart block, dysphagia with nasogastric tube dependence, and microcephaly. Upon learning of the child's death on 8/20/2023, ACS notified OCFS of the child's death, assessed the safety of the surviving siblings, and began to gather information from providers.

The child was hospitalized on 7/20/2023 after experiencing a fever and seizure while in the care of the maternal aunt. The mother and siblings were out of the country for a planned vacation at the time of the medical emergency. There were initial concerns the mother had not provided the aunt and grandmother with the child's medications, leading to her medical condition. These concerns were later alleviated by medical providers, and it was determined the child was given her medications properly, and a language barrier between the aunt and hospital staff initially led to confusion.

The child was discharged home to the care of the mother on 8/15/2023. The child's condition improved enough for her medical providers to discharge her with instructions to the mother to return to the hospital if the child's condition worsened. On 8/19/2023, the child experienced a high fever and sweating. The mother called 911, and the child was transported to the hospital. While en route, the child became unresponsive and was pronounced dead upon arrival at the hospital. The surviving siblings were assessed as safe in the care of the mother following the death of the child.

ACS interviewed the medical examiner following the autopsy. The medical examiner stated the child showed no signs of abuse or maltreatment. The medical examiner stated the cause of death would be pending the lab results that were taken from tissue samples.

ACS offered services in relation to the child's death. Financial assistance for the funeral and childcare services were accepted. The allegations against the mother in the initial SCR report were unsubstantiated and the investigation was closed.

PIP Requirement
ACS will submit a PIP to the New York Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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 SC's date of death was entered with the incorrect year.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS will ensure identifying information is maintained accurately in the case record.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/19/2023 **Time of Death:** 01:00 AM (Approximate)

Date of fatal incident, if different than date of death: 08/18/2023
Time of fatal incident, if different than time of death: 11:00 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	Female	36 Year(s)
Deceased Child's Household	Deceased Child	No Role	Female	11 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	56 Year(s)
Deceased Child's Household	Mother	No Role	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Month(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)

LDSS Response

ACS was informed of the SC's death by the MA on 8/20/2023. ACS was involved with the family due to an open investigation dated 7/25/2023 when the SC was hospitalized while in the care of the MA. There were initial concerns the mother did not obtain the SC's medications prior to leaving the SC in the care of the MA and MGM.

The SC was hospitalized on 7/20/2023 and was admitted and diagnosed with MRSA and sepsis. The SC remained hospitalized until 8/15/2023, when she was discharged to the care of the BM. The BM was instructed to return to the hospital if the SC's symptoms worsened. On 8/18/2023, the SC's symptoms worsened at approximately 11:00 PM. The BM called for an ambulance to transport the SC to the hospital. While en route to the hospital, the SC became unresponsive and was pronounced dead upon arrival. The SSs were assessed as safe in the care of the BM, MA, and MGM throughout the open investigation and following the death of the SC.

ACS interviewed hospital staff that treated the SC prior to her discharge. The SC was initially admitted, and an SCR report was made due to concerns the BM did not provide the MA and MGM with all the SC's medications prior to going on a vacation, causing the SC to have a seizure. ACS attended a provider meeting and the initial concern the BM did not provide the medications to the MA and MGM were clarified. It was determined the BM did provide the medications, they were administered as prescribed, and the initial concern was due to a language barrier between the MA and hospital staff. The SC was discharged home on 8/15/2023 and returned 8/19/2023 when she was pronounced dead upon arrival.

ACS interviewed the ME. The ME stated the SC showed no signs of abuse or trauma. The ME preliminarily stated the

SC's death did not appear to be from abuse or maltreatment. Tissue and fluid samples were taken for further testing and a cause of death was not available at the time the investigation closed.

ACS interviewed the BF by phone as he lived out of the country. The BF expressed no concerns for the BM or maternal family's care of the SC prior to her death.

ACS offered services in relation to the death of the SC and the previously open investigation was closed.

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
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

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: The SC died during an open investigation and their death was not reported to the SCR. A safety assessment of the SSs within 24 hours was not required.				

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: Adequate services were offered in relation to the death of the SC. Some services were accepted and others declined by the family.				

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?	☐	☒	☐	☐

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:
Services were offered on behalf of the SSs in relation to the death of the SC and declined by the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Funeral assistance and child care assistance were provided to the family following the death of the SC. Further bereavement services were declined.

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)
07/25/2023	Deceased Child, Female, 11 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 11 Years	Mother, Female, 36 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SCR report alleged the BM left the SC in the care of the MA and MGM while she left the country with the SSs for vacation. The BM failed to obtain all of the SC's prescribed medication which led to the SC having a seizure while in the care of the MA. The MA called an ambulance and brought the SC to the hospital for treatment.

Report Determination: Unfounded **Date of Determination:** 09/21/2023

Basis for Determination:
ACS met with all family members and relevant collateral contacts. ACS attended a provider meeting with the family and hospital staff treating the SC. It was determined the BM did provide all of the SC's medications to the MA and MGM prior to leaving the country and they were administered as prescribed. The MA did not speak English, and the initial concern the SC did not receive all of her medications was believed to have been a miscommunication between the MA and hospital staff admitting the SC. The SC was admitted to the hospital on 7/20/2023 through 8/15/2023 to treat sepsis and MRSA. The SC passed away on 8/19/2023.

OCFS Review Results:
ACS conducted an investigation that met regulatory requirements and made a determination of the allegations in congruence with the evidence gathered.

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

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No