Child Fatality Report

Report Identification Number: SV-17-046

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

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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		

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 10/09/2017
Initial Date OCFS Notified: 10/19/2017

Presenting Information

SC was diagnosed with adjustment disorder and Lupus in 2016 which required close medical attention. For three weeks, SC had been sick and required medical treatment; however, her mother failed to take SC for treatment until 9/11/17. SC was prescribed an antibiotic on this day but the prescription was never filled. SC's condition deteriorated. On 9/13/17, SC's condition worsened to the point she could not lift her head and was extremely lethargic. The mother's friend took SC to the hospital on 9/13/17 and she was admitted. SC later died on 10/9/17 of complications from Lupus.

Executive Summary

This fatality report concerns the death of a 16-year-old female that occurred on 10/9/17. Due to religious beliefs, her mother declined an autopsy be done on SC. The specific cause and manner of death are unknown.

At the time of SC's death, her family had an open Child Protective Services case with Westchester County Department of Social Services (WCDSS). The case was opened on 9/13/17 with concerns regarding a lack of medical care for SC.

SC was diagnosed with an illness in February 2016 and in December 2016, SC made an informed decision to stop taking her medication to treat the illness. The mother encouraged SC to take her medication but SC refused. SC did not like the side effects of the medication. Medical professionals who treated the child stated the disease is known to flare up unexpectedly, with or without medication. SC's doctors could not say the mother acted in a way that contributed to her death. The doctors felt that even if SC had complied with the recommended treatment plan, the outcome would have been the same.

WCDSS gathered information about the circumstances of SC's death from the mother, SC's team of doctors, school officials, and MH professionals. CW obtained copies of all medical and school records. SC had been ill for approximately three weeks prior to entering the hospital on 9/13/17. SC was in a coma the duration of the investigation and was unable to be interviewed. CW made notable efforts to contact and interview the father of SC, but efforts were unsuccessful. There was an adult sibling who did not live in the home and was not contacted.

CW interviewed SC's doctor who did not believe the child's failure to take her medication was related to her death.

CWs met with the mother on multiple occasions and offered appropriate services in response to the child's death.

WCDSS followed appropriate protocols for when a child dies in an open CPS investigation. WCDSS filed the (7065) agency reporting form for serious injuries, accidents, or deaths of children in foster care and deaths of children in open child protective or preventive cases accurately and timely.

WCDSS indicated the case for the allegation of Inadequate Guardianship. Given the mother's awareness of SC's chronic medical condition and the fact that she was aware SC was not consistently taking her medication, the mother should have been more proactive in seeking treatment for the acute illness for SC prior to her 9/13/17 trip to the hospital.

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

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:
The level of casework activity was commensurate with the case circumstances.

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: 10/09/2017 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Westchester
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: SC was in a coma

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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	16 Year(s)
Deceased Child's Household	Mother	No Role	Female	37 Year(s)

LDSS Response

On 10/19/17, the mother notified WCDSS of SC's death. There were no surviving siblings or other children living in the home. Later this day, CW met with the mother and made referrals for her for counseling and victim's assistance services. She told CW she tried contacting SC's father through relatives but was unsuccessful. The mother provided CW with the father's name and DOB. CW searched for contact information for the father but was unsuccessful.

CW obtained extensive medical, school, and mental health records for SC. CW reviewed CPS history, LE records, and social services records. CW interviewed SC's medical specialists. The doctor said SC refused to take her medications; however, the mother and SC were told that if SC's illness was not treated, it could be very serious. SC had stopped taking her medication in December 2016. SC's primary specialist felt even if the mother had brought SC to the hospital sooner or gave her needed medication, SC still would have died. The primary specialist stated SC's organs were failing and her brain was swollen due to Lupus. The primary specialist said this disease can flare up unexpectedly. The mother refused an autopsy due to religious beliefs. Since there was no autopsy, the doctors were unable to identify the exact cause of SC's death.

The doctors did not make an SCR report when it was learned SC was not taking her medication because they felt the mother was doing everything she could to have the child take her medication.

CW confirmed with SC's doctor's office that SC missed a doctor's appointment in July 2017 due to a lapse in health insurance. The mother never rescheduled after the issue was resolved. SC's doctor's office said they made frequent and several attempts to have the mother bring SC in and were unsuccessful.

CW spoke with SC's counselor of two years who often met with SC and her mother; she had no concerns.

The case that was open at the time of the fatality was appropriately determined and closed on 11/9/17.

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: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

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?	☐	☒	☐	☐

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 parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
Grief counseling referrals were made, but it's unknown if SM engaged.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
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? 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)
09/13/2017	Deceased Child, Female, 16 Years	Mother, Female, 37 Years	Lack of Medical Care	Indicated	No
	Deceased Child, Female, 16 Years	Mother, Female, 37 Years	Inadequate Guardianship	Indicated	

Report Summary:
It was alleged that SC was diagnosed with a disease that required close medical attention and SC also had adjustment disorder. SC had been sick for 3 weeks before her mother took her for medical treatment on 9/11/17. SC's condition deteriorated. SC was prescribed an antibiotic and mother failed to fill the prescription. As a result, on 9/13/17, SC's condition worsened to the point she could no longer lift her head and was extremely lethargic, and mother failed to take SC for emergency medical treatment.

Determination: Indicated | **Date of Determination:** 11/09/2017

Basis for Determination:
Although the death of SC could not directly be attributed to the mother, WCDSS gathered credible evidence to show that

the mother was fully aware of SC's chronic medical condition and was aware SC was not consistently taking her medication. SC had been ill three weeks before her death and her mother should have been more proactive in seeking medical treatment for SC.

OCFS Review Results:
CW had extensive interviews with SC's doctors, medical professionals, and SM. SC was unable to be interviewed as she was physically unable to do so throughout the investigation. CW collected medical records, school records, and reviewed CPS history. WCDSS completed all safety assessments accurately and on time. CW made appropriate referrals for the mother.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/26/2016	Deceased Child, Female, 14 Years	Mother, Female, 35 Years	Swelling / Dislocations / Sprains	Unfounded	No
	Sibling, Female, 17 Years	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Female, 17 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Female, 14 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report alleged that on 2/13/16, the mother got angry with SC and lost control. The mother hit her repeatedly with a belt. SC sustained swelling to her arm as a result. The roles of SS and the unnamed cousin were unknown.

Determination: Unfounded **Date of Determination:** 04/01/2016

Basis for Determination:
Mother and SC both stated that mother did not hit SC on her arms, she only hit SC on her legs with a belt. SC said she sustained a red mark by her knee as a result. Mother had never hit the child before. The sibling confirmed this. There was no credible evidence to indicate the allegations.

OCFS Review Results:
CW interviewed all parties, contacted several collaterals, made home visits, and correctly unfounded the report. The RAP and all safety assessments were completed accurately and on time. CW verified that the family was receiving therapy.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/10/2015	Deceased Child, Female, 14 Years	Mother, Female, 35 Years	Lack of Supervision	Unfounded	Yes
	Deceased Child, Female, 14 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 16 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 16 Years	Mother, Female, 35 Years	Lack of Supervision	Unfounded	

Report Summary:
An SCR report alleged the mother left SC and SS home alone for three days in a row. The children are not mature enough to be without adult supervision for three days. SC had a history of suicidal ideations, depression, and self harming behaviors. The mother and SC had a verbal altercation prior to her leaving the home for three days.

Determination: Unfounded | **Date of Determination:** 12/16/2015

Basis for Determination:
Mother and both children stated there was a 37-year-old cousin who was in the home visiting the entire time mother was gone. Mother was at her sister's house which is a couple of houses down the street. Mother stated this is the first time she had ever done this and will not do it again. The children corroborated this has never happened before. The adult cousin also confirmed she was in the home the whole time the mother was gone. There were several subsequent home visits where no further incidents had occurred.

OCFS Review Results:
CW spoke with several collaterals such as school officials, relatives, medical professionals, and SC's therapist. CW also provided the mother with therapy referrals for herself. CW performed several searches of the family such as CPS history, criminal history, and a sex offender clearance. No results were found for the family.

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

Issue:
Failure to provide notice of report

Summary:
The record does not reflect the father received the required written notice of the existence of the SCR report.

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

Action:
Each subject and each adult "other person named" in the report, including non subject parents not actually listed in the report must receive a notification letter.

[redacted]

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

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

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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