Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-064

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

Issue Date: May 06, 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: 3 year(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 12/16/2023
Initial Date OCFS Notified: 12/16/2023

Presenting Information

On 12/16/2023, Westchester County Department of Social Services (WCDSS) received an SCR report concerning the death of the 3-year-old subject child. The SCR report alleged the subject child was not feeling well and the mother contacted the father to pick the child up around 4:30 AM on 12/16/2023. Around 5:30 AM, the father brought the subject child to the hospital where she passed away at an unknown time. The subject child was an otherwise healthy child and the mother, father, and maternal grandmother provided no explanation for her death. There were further concerns that the mother and maternal grandmother's home had no heat or food and was a health and safety concern for the subject child and surviving twin sibling.

Executive Summary

This report concerns the death of a 3-year-old subject child which occurred on 12/16/2023. At the time of her death, the subject child resided with her mother, surviving twin sibling, 15-year-old maternal aunt, and maternal grandmother. The father of the subject child and twin sibling had regular contact with the children but resided in another home. The surviving twin sibling and the maternal aunt were assessed to be safe in the care of their respective parents.

On 12/11/2023, the subject child and twin sibling were sent home from daycare as they were ill. The twin sibling recovered quickly; however, the subject child was not better by 12/13/2023, so the mother and father brought her to her pediatrician. The subject child was observed to have a slight fever, but to be otherwise well and was discharged with instructions to be administered a fever reducer. Throughout the rest of 12/13/2023 and 12/14/2023, the subject child appeared to be improving. On 12/15/2023, the subject child's condition deteriorated. Around 9:00 PM that evening, the parents brought the subject child to an urgent care facility where she was diagnosed with an ear infection and prescribed an antibiotic. Upon returning home on 12/15/2023, the mother, subject child, and twin sibling co-slept in the mother's bed. Around 1:00 AM on 12/16/2023, the mother noticed the subject child was cold and contacted the father for help. The father responded to the mother around 4:00 AM and arrived at the home to take the subject child around 4:30 AM. The father returned to his home with the subject child but was concerned as her breathing was irregular, so he transported the subject child to a nearby hospital emergency room. While in the waiting room, the father noticed the subject child was not breathing and requested immediate medical attention. Hospital staff initiated live-saving measures; however, the subject child was pronounced deceased. Hospital records noted the subject child was positive for Influenza B.

An autopsy was completed and WCDSS spoke with the medical examiner who stated the subject child was positive for Influenza B. There was no evidence of abuse or neglect found during the autopsy. As of the writing of this report, the final autopsy report was not yet available, and the cause and manner of death remained undetermined. The law enforcement investigation remained ongoing pending the final autopsy report; however, there were no charges or arrests and no suspicion of criminality related to the death at the time the CPS investigation was closed.

The CPS investigation was closed, and the allegations of DOA / Fatality and Inadequate Guardianship related to the death of the subject child were unsubstantiated against the mother, father, and maternal grandmother. There was not a preponderance of evidence that any of the adults were responsible for the death of the subject child and the mother and father acted appropriately in seeking medical attention for the subject child when she was ill. The allegations of Inadequate Food / Clothing / Shelter and Inadequate Guardianship related to the unsafe home environment for the surviving twin sibling were unsubstantiated against the mother and maternal grandmother as the home was found to meet minimal standards for safety.

WCDSS discussed fatality related services with the mother and made a referral for services for the family.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
WCDSS gathered information from familial and collateral sources as necessary to make an appropriate determination of the allegations; however, service needs were not explored with the father, maternal grandmother, or maternal aunt.

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: 12/16/2023 **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 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	15 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	23 Year(s)

LDSS Response

Immediately upon receipt of the SCR report, WCDSS initiated an investigation, coordinated with law enforcement, interviewed family members, gathered information from pertinent collateral sources, and assessed the safety of the surviving twin sibling and 15-year-old maternal aunt.

The mother and father were interviewed and provided substantively similar timelines of the events preceding the death of the subject child. The subject child and surviving twin sibling had been sent home ill from daycare on 12/11/2023 and the twin sibling recovered quickly. The subject child was still ill on 12/13/2023 and the parents brought her to her pediatrician. The parents stated the pediatrician said the subject child had a slight fever but was otherwise healthy and recommended the parents administer an over-the-counter fever reducer, which they did as directed. The subject child seemed to get better for a few days; however, on 12/15/2023 her condition worsened. The parents brought the subject child to an urgent care facility around 9:00 PM on 12/15/2023, and she was diagnosed with an ear infection and prescribed an antibiotic. The mother and subject child returned home, and the mother, subject child, and surviving twin sibling went to bed in the mother's bed. Around 1:00 AM on 12/16/2023, the mother noticed the subject child was cold and contacted the father for help. The father responded and picked the subject child up from the mother's home around 4:30 AM. The father was concerned for the subject child's breathing and transported the subject child to a nearby hospital's emergency department. The father requested immediate medical attention when he was worried the subject child was not breathing. Medical staff took the child and initiated life-saving measures; however, shortly thereafter the father was told the subject child was deceased.

Immediately after the death of the subject child, the mother and surviving twin sibling moved into the home of the father

which was observed to be clean and appropriate. The surviving twin sibling was seen by medical professionals on 12/18/2023 and was found to be healthy with no concerns. WCDSS noted no safety concerns for the surviving twin sibling in the care of the parents.

WCDSS interviewed the maternal grandmother and 15-year-old maternal aunt. The grandmother and aunt both stated they were aware that the subject child was ill but that the mother and father had brought her for medical attention on two occasions due to their concerns. The grandmother and aunt reported no concerns for the mother and father's treatment and care of the subject child or surviving twin sibling.

WCDSS corresponded with staff at the subject child and surviving twin sibling's daycare agency who reported no concerns for the children's health and safety in the care of the mother and father.

Records were gathered from the subject child and surviving twin sibling's pediatrician and showed that both children were up to date with well visits and immunizations and the practice reported no concerns for the children's care with the parents.

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 investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The fatality was referred to Westchester County's Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066970 - Deceased Child, Female, 3 Year(s)	066973 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
066970 - Deceased Child, Female, 3 Year(s)	066973 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
066970 - Deceased Child, Female, 3 Year(s)	066975 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
066970 - Deceased Child, Female, 3 Year(s)	066975 - Father, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
066970 - Deceased Child, Female, 3 Year(s)	066974 - Grandparent, Female, 44 Year(s)	DOA / Fatality	Unsubstantiated
066970 - Deceased Child, Female, 3 Year(s)	066974 - Grandparent, Female, 44 Year(s)	Inadequate Guardianship	Unsubstantiated
066971 - Sibling, Female, 3 Year(s)	066973 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066971 - Sibling, Female, 3 Year(s)	066973 - Mother, Female, 26	Inadequate Guardianship	Unsubstantiated

	Year(s)		
066971 - Sibling, Female, 3 Year(s)	066974 - Grandparent, Female, 44 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066971 - Sibling, Female, 3 Year(s)	066974 - Grandparent, Female, 44 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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)?	☒	☐	☐	☐
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?				

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:
The record did not reflect that service needs were explored with the father, maternal grandmother, or maternal aunt.

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? Yes
Explain:
A referral for bereavement services was made on behalf of the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were discussed with the mother and a service referral was made on behalf of the family.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

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

There was no known 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