Child Fatality Report

Report Identification Number: NY-22-043

Prepared by: New York City Regional Office

Issue Date: Nov 17, 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	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: 15 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 06/10/2022
Initial Date OCFS Notified: 06/10/2022

Presenting Information

An SCR report was received that alleged on 6/9/22, at approximately 11:00PM, the adult sibling discovered the 15-year-old female subject child in the living room laying face up on the couch and unresponsive. The adult sibling called 911. Law enforcement and emergency medical services responded to the home. The child was pronounced deceased on 6/10/22 at 12:36AM. The child was otherwise healthy and the adult sibling did not have an explanation for her death. The mother and father had unknown roles.

Executive Summary

On 6/10/22, the New York City Administration for Children's Services (ACS) received an SCR report regarding the death of the 15-year-old female subject child. The report alleged DOA/Fatality and Inadequate Guardianship against the 20-year-old sibling. At the time of the death, the child resided with her mother, but often spent time at her 22-year-old sibling's home. There were no minor siblings or children in either household. The father of the child resided outside of the country. The 20-year-old sibling did not reside in either home and the record did not reflect she had any caretaking responsibilities for the child.

Through interviews with collaterals and family, it was learned that on 6/9/22, the mother picked the child up early from school, brought her home and then left to go to the salon. During that time, the child and mother were communicating via telephone about cleaning the home. An adult cousin stopped by around 5:00PM to retrieve a couple of things, before going to the 22-year-old sibling's home. The child asked to go with him to the sibling's home and he agreed to take her. The cousin brought the child to the adult sibling's home and left shortly after. The child stayed to spend the night, which was typical for her to do. The 22-year-old sibling and her boyfriend returned to the apartment at 11:00PM and discovered the child lying face up on the sofa and she was cold and limp. The adult sibling called 911 and the mother upon finding the child. Emergency medical services responded to the home. The child was pronounced deceased at the hospital at 12:36AM.

An autopsy was performed; however, the final report was pending further testing at the time this report was written. The preliminary examination showed there were no indicators of physical abuse and the child only had minor marks from normal activity. The medical examiner reported that the child's death appeared to be a suicide. There were several bright green pills found in her stomach. The medical examiner stated it was believed the child intended to overdose, as she had a history of suicidal ideations. In addition, law enforcement discovered a note near the child. Law enforcement's investigation was pending at the time this report was written.

Upon receipt of the SCR report, the 20-year-old sibling was listed as the alleged subject. During the investigation, it was learned the 22-year-old sibling was who helped care for the child and who's home the child was at the night of the incident. It appeared from the information gathered that the 20-year-old sibling was incorrectly reported as the subject and there were no efforts documented to correct this information with the SCR prior to case closure. In addition, the record did not reflect the 20-year-old sibling was interviewed. ACS connected the family to bereavement services and the child's school assisted in paying for the child's funeral. The investigation was unfounded and closed on 8/5/22.

PIP Requirement

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
There were no surviving siblings or children in the home; therefore, the completion of the safety assessment tools was not required.

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:
ACS gathered sufficient information to determine the allegations. The record did not reflect that the 20-year-old sibling was interviewed. In addition, there were no attempted interviews with the adult cousin, who last saw the child alive.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The record did not reflect that the 20-year-old sibling was interviewed face-to-face.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/10/2022 **Time of Death:** 12:36 AM

Date of fatal incident, if different than date of death: 06/09/2022
Time of fatal incident, if different than time of death: Unknown

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 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	Alleged Victim	Female	15 Year(s)
Deceased Child's Household	Mother	No Role	Female	40 Year(s)
Other Household 1	Adult Sibling	No Role	Female	22 Year(s)
Other Household 2	Adult Sibling	Alleged Perpetrator	Female	20 Year(s)

LDSS Response

Upon receipt of the SCR report on 6/10/22, ACS initiated their investigation, contacted LE, spoke to the ME, interviewed the family, and completed a home visit.

ACS gathered information from the mother via face-to-face and phone interviews. On 6/9/22, the mother dropped lunch off to the child at school. The child asked to leave school early, and the mother agreed. The mother took the child to her home and asked her to clean her room. The mother then left for the salon, leaving the child home alone. The child called the mother multiple times to inform her she washed the dishes and inquired on how to clean the bathtub. The mother reported she later discovered the child cleaned the entire house. While home alone, an adult cousin stopped to pick up a cell phone. The child told the cousin she wanted to go to the 22-year-old sibling's home, and he agreed to bring her, as he was stopping there anyway. The cousin last saw the child alive at 5:00PM, prior to leaving the sibling's home, and told the family he had no concerns for her at that time. Throughout the evening, the mother was texting the child and she was not answering.

ACS interviewed the 22yo sibling and she reported that she and the child had a very close relationship. While the child was at her home, the sibling called the child to inquire about what she wanted for dinner. The child was not responding to the siblings' outreaches, but the sibling explained it was normal for the child to turn her phone on do not disturb when she took a nap. The sibling returned home around 11:00PM and discovered the child on the sofa and she was stiff and cold. The sibling denied seeing any pills or bottles near the child. The sibling contacted 911 and the mother. The sibling denied the child was having any problems with friends or in school, and reported her to be happy and well cared for. The father resided out of the country. He was interviewed via telephone and reported no concerns for the child's mental health.

It was learned from the family that the child had attempted to commit suicide in September 2017. The child ingested pills and was taken to the hospital. The child received inpatient mental health treatment followed by outpatient mental health treatment. ACS documented they were unable to receive records, as the family could not remember the name of the practice; however, this information was documented in a historical case from 2018 involving the 20yo sibling. The family reported the child stopped attending therapy because she stated she was feeling better and felt uncomfortable continuing to talk about something that happened in the past. The family moved to the United States five years prior, and the child struggled with the change and language barrier, which is believed to be why she attempted suicide in 2017. The family had no inclination that the child was struggling with her mental health around the time of her death and were unaware where she had gotten pills from.

ACS contacted the child's school to determine if they had concerns for her mental health. School staff explained they did not observe any concerning behavior. The child was described as bubbly, happy, polite, and friendly. The child was passing all her classes and expressed excitement about the following school year. The child was in an English as a New Language class and developed good relationships with her peers and teachers. Peers shared the child had an 18- or 19-year-old boyfriend. In the child’s last texts to the boyfriend, she had expressed her love for him, and hope that he did not feel betrayed by her. Staff reported the child’s death was a huge loss for the community, and they would be assisting the family by paying for the burial. ACS requested records from the child’s doctor’s office, who denied receiving the request and asked it to be resent. The office verbally confirmed the child was a patient, but no other information was received regarding the child’s medical care.

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 investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061846 - Deceased Child, Female, 15 Yrs	061849 - Adult Sibling, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
061846 - Deceased Child, Female, 15 Yrs	061849 - Adult Sibling, Female, 20 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:

The record did not reflect an interview with the 20yo sibling. The BF resided outside of the country and was interviewed via telephone. The adult cousin was the last person to see the SC alive and the record did not reflect attempts to interview him.

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? Yes
Explain:
The mother and adult siblings were referred to grief counseling services.

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

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