Child Fatality Report

Report Identification Number: NY-19-002

Prepared by: New York City Regional Office

Issue Date: Jul 05, 2019

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: 14 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 01/02/2019
Initial Date OCFS Notified: 01/05/2019

Presenting Information

On 1/5/19, the SCR registered a report which alleged the 14-year-old SC was a diabetic who required insulin. The report alleged that on 12/30/18 the SC collapsed in the home while in the care of the parent substitute (PS). The SC had been out of insulin for at least two days and at the time of the incident the mother was at the pharmacy filling his prescription. EMS was called and the SC was transported to the hospital where he was resuscitated and transferred to another hospital for a higher level of care. The SC remained in ICU and declared brain dead on 1/2/19.

Executive Summary

The SC was 14 years old when he died on 1/2/19. The autopsy report listed the cause of death as complications of insulin-dependent diabetes melliutus and the manner of death undetermined.

The SC resided with his mother and the PS, and the father had consistent contact with the SC. At the time of the fatality, ACS was investigating an initial report dated 12/30/18 with allegations of LMC and IG of the SC by the parents and the PS.

On 1/5/19, SCR registered a report with allegations of DOA/FATL, LMC and IG of the SC by the parents and the PS.

According to the mother, on 12/30/18 she woke up at 12:18 P.M. and noticed there was vomit behind the toilet; therefore, she went to check the SC and found him asleep. The mother said she returned later to check the SC and he told her that he was not feeling well. The mother noticed the SC had no insulin in the home, therefore, she called the endocrinologist for a prescription refill. The mother said she was unable to fill the prescription at her usual pharmacy as they were no longer accepting the SC's medical insurance. The mother then walked to another pharmacy, but the cost of the medication was too high and she was unable to reach the endocrinologist to call in a prescription for a generic brand. The mother said she began to cry and the pharmacist gave her the insulin with the payment pending. When the mother returned home, her neighbors informed her the SC was transported to the hospital via ambulance. The SC was accompanied by the PS. The mother said she did not have her wallet so she ran to the hospital and found the SC was intubated. Hours later, the SC was transferred to another hospital for a higher level of care. The SC remained on life support until he was pronounced dead on 1/2/19. ACS was unable to obtain the time line leading to the hospitalization.

ACS conducted the investigations of the two reports simultaneously. The investigations were completed timely and relevant collateral contacts were made.

ACS and the NYPD conducted joint interviews with the staff at the SC's school; the nurse had no concerns about the SC administering his medication as she stated he was very responsible and knowledgeable of his treatment. The NYPD did not find any criminality involving the SC's death; therefore, no arrest was made.

ACS contacted the medical staff from the ER and the ME who indicated the SC died due to complications of his diabetes. The SC's endocrinologist stated the mother missed an appointment in November 2018 at which time he would have been given a 6-month prescription for his medication. The mother waited until 12/30/18 to call for the refill. The mother indicated she attempted to reschedule this appointment but the was no date available until January 2019.

ACS interviewed the subjects of the report at the beginning of the investigations. Shortly after the SC's burial on 1/9/19,

the mother left NYS to be with her family and the PS was residing with relatives. There were no surviving children in the home, therefore, no additional action was deemed necessary. ACS provided the family resources for bereavement services.

On 2/28/18 and 3/6/19, ACS substantiated the IG and LMC allegations of the reports against the mother and the PS because they failed to monitor the SC's intake of his medication and to refill his prescription in a timely manner. The allegations were unsubstantiated against the father because he was not made aware the SC needed a refill and he had monitored the SC's intake while the SC was in his care.

The allegation of DOA/FATL against the mother and the PS was substantiated as their failure to refill the SC's prescription caused him to go into cardiac arrest, which resulted in his untimely death. ACS unsubstantiated the allegation against the father because he was unaware the SC needed to have his prescription filled and had monitored the SC's intake during the days he had the SC in his care.

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

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 notes a consultation took place, but no details noted.

Explain:
No other children in the home.

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: 01/02/2019 **Time of Death:** 08:20 PM

Date of fatal incident, if different than date of death: 12/30/2018
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? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
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	Alleged Victim	Male	14 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Other - Parent Substitute	Alleged Perpetrator	Male	37 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	37 Year(s)

LDSS Response

According to the mother, the SC was fine on 12/29/18, he played games and was on his computer for most of the day. The mother reported the SC also interacted well with her and had no problems with his appetite. The mother indicated the SC was mature and had begun to administer his insulin four years prior to the incident.

The mother reported on 12/30/18 she woke up at 12:18 P.M. and went to the bathroom where she noticed there was vomit behind the toilet. The mother said she went to check the SC, but he was asleep. The mother said when she returned to check the SC (no timeline provided), he looked pale and said he was not feeling well. At that time, the SC informed the mother he had no insulin in the home. The mother then called the father to see whether he had any medication at his home, but he had none. The mother then called the endocrinologist who called in a refill to the pharmacy and she left the SC with the PS. However, when the mother arrived at the usual pharmacy, she learned they no longer had a contract with the SC's medical insurance. The pharmacist forwarded the prescription to another pharmacy; however, the receiving pharmacy did not cover the medicine because it was not generic. The mother said she tried calling the endocrinologist again, but did not get a response. The mother said she began to cry and the pharmacist filled the prescription with the payment pending. The

mother said when she returned home, her neighbors told her the SC had been transported to the hospital.

The father reported the SC stayed with him from 12/23/18 through 12/27/18 and during this period, he watched the SC administer his insulin and check his sugar levels. The father said on 12/30/18, the mother called him at 2:00 P.M. because the SC had no insulin at her home. The father had no medication so the mother went to the pharmacy. He received another call from the mother who told him the SC was admitted at the hospital. The father reported there were incidents in the past when he would take the SC to the doctor and was questioned about the SC's medication as the result of the medication monitor sometimes reflected the SC had not taken his insulin for three or four days. The father said the mother always said she had no idea the SC had not taken his insulin. The father admitted he never had a discussion with the mother regarding the need to supervise the SC's treatment.

The PS stated once the SC told the mother he had no insulin, she checked his blood sugar levels, and then left to go to the pharmacy. The PS said the SC looked pale so he laid the SC on the bed and began talking to him. The SC then got up from the bed to throw up in the bathroom, and he heard something hit the floor. The PS said when he entered the bathroom the SC was lying on the floor; the PS then called 911. The PS said EMS was taking too long so he picked up the SC and carried him down the stairs as he yelled for help. The PS said once he was in front of the building he considered taking a cab, but the EMS then arrived.

ACS staff and the NYPD interviewed the SC's school nurse and guidance counselor. The school nurse and other staff reported the SC was an honor student with no behavioral or attendance problems. The nurse reported the SC was very responsible and knowledgeable regarding his medical condition and treatment. The nurse stated the SC always administered his insulin, and she would assist him with monitoring his sugar levels. According to the staff, the mother was sometimes unresponsive when the SC's sugar was high and they often contacted the father who would immediately come to the school or send the PGM to pick up the SC.

ACS indicated the reports.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: There was no documentation of an MDT investigation; however, the investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048913 - Deceased Child, Male, 14 Yrs	050049 - Father, Male, 37 Year(s)	Lack of Medical Care	Unsubstantiated

048913 - Deceased Child, Male, 14 Yrs	048914 - Mother, Female, 33 Year(s)	Lack of Medical Care	Substantiated
048913 - Deceased Child, Male, 14 Yrs	050049 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
048913 - Deceased Child, Male, 14 Yrs	050049 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
048913 - Deceased Child, Male, 14 Yrs	048914 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
048913 - Deceased Child, Male, 14 Yrs	048915 - Other - Parent Substitute, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
048913 - Deceased Child, Male, 14 Yrs	048915 - Other - Parent Substitute, Male, 37 Year(s)	DOA / Fatality	Substantiated
048913 - Deceased Child, Male, 14 Yrs	048914 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
048913 - Deceased Child, Male, 14 Yrs	048915 - Other - Parent Substitute, Male, 37 Year(s)	Lack of Medical Care	Substantiated

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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
N/A

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? N/A
Explain:
There were no other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was offered bereavement services; however, it is unknown whether they followed up on this service.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	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?	N/A
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)
12/30/2018	Deceased Child, Male, 14 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 14 Years	Mother, Female, 33 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 14 Years	Other - Parent substitute, Male, 37 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 14 Years	Other - Parent substitute, Male, 37 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 14 Years	Father, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 14 Years	Father, Male, 37 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
On 12/30/18, the SCR registered a report stating the 14-year-old SC was prescribed insulin for his diabetes, and the mother allowed him to administer his medication without supervision. The report alleged that as a result, the SC did not take his medication for two days because he was out of insulin. The report stated the SC went into cardiac arrest, but was resuscitated. The report alleged the mother and the PS failed to have the necessary prescription filled.

Report Determination: Indicated | **Date of Determination:** 02/28/2019

Basis for Determination:
ACS substantiated the allegations of IG and LMC of the SC by the mother and the PS because they were aware of his medical condition and failed to supervise that he properly administered his insulin. In addition, they failed to fill his prescription timely.

ACS unsubstantiated the allegations of IG and LMC of the SC by the father because he supervised the SC and administered the medication during the days he stayed with the father and on 12/27/18, before the SC returned to mother's home.

OCFS Review Results:
ACS initiated the investigation timely and made a timely determination of the report. The investigation was thorough even though the family declined ongoing contact with ACS after the SC's burial. Relevant collateral contacts were interviewed and an appropriate determination was made. However, all the relevant notices were not issued.

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

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

The family had no CPS history.

Known CPS History Outside of NYS

The family had no known CPS history outside 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