Child Fatality Report

Report Identification Number: NY-19-119

Prepared by: New York City Regional Office

Issue Date: Apr 08, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 13 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 11/05/2019
Initial Date OCFS Notified: 11/06/2019

Presenting Information

On 11/5/19, the SC had been having trouble breathing all day and the parents were aware; but, failed to seek medical attention. In the evening, the SF checked on the SC and found her unresponsive. The parents took the SC to the police station and an officer transported the SC to the hospital. The SC was admitted to Pediatric Intensive Care Unit with potential brain damage, she was pronounced dead at 11:55 PM on 11/5/19. The SC was diagnosed with severe asthma for which she was prescribed daily medication in a pill form as well as a nebulizer breathing machine. The parents failed to ensure the SC was taking her medication as well as administering her nebulizer treatments.

Executive Summary

On 11/6/19, ACS initiated the investigation by contacting the hospital, ME, and LE to obtain information regarding the incident.

The Specialist learned when the SC arrived at the ER, she presented with a collapsed lung and was blue in color. The Dr. was concerned the SC was sick throughout the day and the parents waited too long to seek medical care. The Dr. stated the parents should have known better because the same incident occurred on 8/1/18. At the time, the SC was brought in due to passing out from an asthma attack. The SC remained in the ICU for 5 days. Upon discharge the parents and SC were provided with asthma medication. The Dr. told the Specialist the SF was engaged; however, the SM appeared to be "out of it" and “loopy, but not inebriated.” The hospital staff reported similar concerns regarding the incident, and the parents' reaction to the death of the child.

LE reported that the parents arrived at the precinct at 7:20 PM, seeking medical assistance for the SC stating she was having trouble breathing. The SC appeared limp and lifeless as they initiated CPR and transported her to the ER. LE reported the SM took longer to comprehend and process the event. LE found no criminality. The Dr stated the SC died of complications of asthma. The ME reported the parents delayed in seeking medical care for the SC.

The SF told the Specialist the SC was good with taking her medication and if she had an issue, she would inform him; however, on the day of the incident, he believed the SC did not take her pill and may have taken only the nebulizer treatment. The SF stated he and the SM were not aware the SC was sick until approximately 5:00 PM when the SM observed the SC’s stomach was moving up and down; it was then that they decided to take the SC to the hospital. The SF said the SC collapsed in his arms as he exited the building.

The SM’s account of the incident was similar to that given by the SF. The SM added that the SC was too weak to stand so she pushed her from step to step. The SM did not contact 911 because she also believed that the patrol car would arrive at the ER faster than to wait for an ambulance. Regarding the SM’s demeanor on the day of the incident, the SM stated she had taken medication. The Specialist confirmed the information with the SM’s physician. The parents reported they had no DV incidents and no mental health conditions. Both parents reported they did not see the SC take her medication.

On 11/14/19, the Specialist interviewed the SC’s primary care physician, who reported the SC’s last wellness checkup occurred on 9/21/18. She was last seen on 2/4/19 for wheezing and a cough; she was treated and released to the parents. The SC’s immunizations were up to date and there were no signs of abuse or neglect. According to the PCP, the SC was diagnosed with “mild persistent asthma without complication.” The SC was prescribed multiple medications in addition to a nebulizer. The Dr. advised the parents if the SC should experience respiratory distress, they should take the SC to the

ER.

The Specialist documented that throughout the home, there was a smell of cigarette smoke; however, the SM reported she smoked only in the bathroom. The Specialist documented the SC's basic needs for food clothing and shelter were met. However, the Specialist noted that there were expired and unused bottles of prescribed medications. In addition, prescriptions for refills that were sent to the pharmacy were not picked up.

The ME listed the cause of death of the SC as asthma and the manner of death natural.

On 12/23/19, ACS unsubstantiated the allegation C/T/S of the SC by the parents citing there was no evidence gathered that the SC was choked; the cause of death was asthma. ACS also unsubstantiated the allegation of DOA/Fatality citing the preliminary cause of death was asthma.

ACS substantiated the allegation of LMC, and cited that the parents failed to ensure the SC received appropriate care to treat her condition.

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 has detail of the consultation.

Explain:
Case investigation was initiated in a timely manner. Supervisory directives were followed and were appropriate. The safety assessments were adequate as there were no surviving children or siblings in the home. Staff appropriately addressed the allegations.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination

Child Fatality Report

Summary:	ACS unsubstantiated the allegation of DOA/Fatality when there was credible evidence the parents' inactions contributed to the death of the child. The child was not being properly supervised regarding her medication management and died as a result.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/05/2019 **Time of Death:** 11:55 PM

Time of fatal incident, if different than time of death: 07:20 PM

County where fatality incident occurred: New York
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

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	Female	13 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	67 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	56 Year(s)

LDSS Response

ACS initiated an investigation into the death of the SC that occurred on 11/5/19. The Specialist learned from the parents that it was approximately 5:00 PM on 11/5/19, that they realized the SC was having difficulty breathing. They assisted the

SC while she got dressed and helped her down the stairs. As they approached the police precinct located next to the case address, the SC collapsed. The parents solicited medical assistance from LE because they believed they would receive help quicker than contacting 911 and to wait for an ambulance. The parents said the SC was very responsible and they were sure she took her medication although they did not see her take it. The parents declined services.

The assigned LE officer reportedly went to the case address that was approximately ten feet away from the precinct. Upon arrival at 7:19 PM, the SC's lifeless body was observed on the doorstep already performing CPR from an officer. LE drove the SC to the ER where the SC was in a vegetative state for a few hours before the Dr. pronounced her dead. LE closed their case based on the preliminary report that the SC died of Bronchial Asthma and they found no criminality.

The ER staff reported that the parents stated that the SC had been sick all day and that she took her medication; however, neither of the parents saw her take any medication. The ER staff reported the parents delayed seeking medical care for the SC which resulted in the collapse of her lungs. The staff reported the SM appeared to be in a "daze". ACS received documentation that reflected the SM was under the care of her physician and had been prescribed medications.

On 11/7/19, the Specialist interviewed the MGF who reportedly had no concerns regarding the care the parents gave the SC. He noted he had seen the SC use the ventilator effectively.

On 11/6/19, the school staff reported the SC had good attendance and she was a strong and lovely student. A school staff reported one issue that occurred two years ago concerning the SC's hygiene that was brought to the parents' attention and it was quickly resolved. On 11/12/19, the Specialist received information from the SC's school that reflected they had no medication at the school for the SC.

On 11/16/19, the SC's PCP reported the SC had a mild case of asthma and there were no concerns with the care the parents gave in the past.

On 12/23/19, ACS substantiated the allegations of LMC and IG of the SC by the parents citing the results of their investigation. ACS cited both parents failed to meet a reasonable minimum standard of care for the child within commonly accepted societal norms. ACS stated the parents failed to ensure that the SC received the appropriate medical care. ACS wrote that the SC was diagnosed with asthma and had a severe attack in August of 2018 where she was hospitalized for five days in the Pediatric Intensive Care Unit. It was noted that the parents were provided with educational materials and extensive training on Asthma. The SC was prescribed multiple asthma medications and the parents failed to ensure the SC was taking the medications as prescribed.

ACS noted that at the time of her death, the SC had bottles of medications that were unused, expired or that were not refilled. The SC was prescribed medications with multiple refills in August 2018 and February of 2019 that were never completed. According to ACS, the parents were aware the SC was not feeling well all day and they sought medical treatment only after the SC had difficulty breathing; she collapsed while being taken to the car. ACS wrote, upon arrival to the ER, the SC's lungs collapsed, and she was not breathing for a few hours prior to being pronounced dead.

On 12/23/19, ACS unsubstantiated the allegation of DOA/Fatality by the parents citing the cause of death asthma. ACS' decision regarding this allegation was not appropriate as there was evidence of the parents' inaction contributing to the death of the child.

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 investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: The case documentation did not reflect an MDT response.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053208 - Deceased Child, Female, 13 Yrs	053209 - Mother, Female, 56 Year(s)	DOA / Fatality	Unsubstantiated
053208 - Deceased Child, Female, 13 Yrs	053209 - Mother, Female, 56 Year(s)	Inadequate Guardianship	Substantiated
053208 - Deceased Child, Female, 13 Yrs	053209 - Mother, Female, 56 Year(s)	Lack of Medical Care	Substantiated
053208 - Deceased Child, Female, 13 Yrs	053210 - Father, Male, 67 Year(s)	DOA / Fatality	Unsubstantiated
053208 - Deceased Child, Female, 13 Yrs	053210 - Father, Male, 67 Year(s)	Inadequate Guardianship	Substantiated
053208 - Deceased Child, Female, 13 Yrs	053210 - Father, Male, 67 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?	☐	☒	☐	☐
Family Members	☐	☐	☐	☒
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?	☒	☐	☐	☐

Additional information:
N/A

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 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 surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Yes but the parents declined.

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?	N/A
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 history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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