Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-075

Prepared by: New York City Regional Office

Issue Date: Dec 17, 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: 15 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/22/2019
Initial Date OCFS Notified: 06/22/2019

Presenting Information

On 6/22/19, the SCR registered a report stating that on 6/16/19 the 15-year-old SC was diagnosed with strep throat and prescribed an antibiotic. The mother and parent-substitute (PS) gave the SC only one dose of medication on 6/19/19 as she was unable to eat and was only drinking water. The report alleged the SC's health did not improve, and the adults did not seek additional medical attention. On 6/22/19, at 12:00 P.M., the mother found the SC unresponsive and cold to the touch. The mother and the PS called 911, EMS responded to the call and found that rigor mortis had already set. The report stated the mother and PS were not able to provide a plausible explanation for the SC's death, and as a result the death was considered suspicious.

Executive Summary

The SC was 15 yo when she died on 6/22/19. The autopsy report listed the cause of death as septic complications of group A streptococcus pharyngitis and the manner of death as natural.

At the time of the fatality, the SC resided with the mother and the PS. The SC's father died in 2004.

On 6/22/19, the SCR registered a report regarding the death of the SC. The allegations of the report were DOA/Fatality, LMC and IG of the SC by the mother and the PS.

According to ACS' investigation, the SC had been ill for several days before the mother took her to the ER on 6/16/19. The SC was diagnosed with an infection and required an antibiotic. However, the doctor discharged the SC and stated the prescription for the antibiotic would be called in to the pharmacy. Several inconveniences arose involving the prescription and the mother was unable to pick up the prescription until 6/19/19. The SC's condition worsened as she felt tired and refused to eat. The mother reported that she stopped giving the SC the antibiotic, because it had to be taken with food and the SC refused to eat anything. Despite the circumstances, the mother did not return to the ER with the SC.

ACS initiated the investigation timely and confirmed there were no surviving children residing in the home.
ACS completed a home assessment and determined there were no safety concerns in the home prior to the SC's death, there were adequate provisions for the SC and the home was clean.

ACS contacted the NYPD and other first responders and there was no suspicion of criminality surrounding the death of the SC. ACS did not ascertain from the ME whether the SC's untimely death could have been prevented, if the mother had given the SC the antibiotic or taken her to the hospital once the SC's condition worsened.

On 12/6/19, ACS substantiated the allegations of LMC and IG of the SC by the mother and the PS because they failed to give the SC the medication that was prescribed for her medical condition and did not return to the ER once the SC's condition worsened. ACS unsubstantiated the allegation of DOA/FATL citing the SC died of natural causes. However, ACS did not consider the legal definition of abuse as the mother and the PS created a substantial risk of harm to the SC by other than accidental means that would be likely to cause the death of the SC.

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

Explain:
N/A

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: 06/22/2019 **Time of Death:** 12:20 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 12:09 PM
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? No - Not needed given developmental age or circumstances

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	Alleged Perpetrator	Female	51 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	46 Year(s)

LDSS Response

ACS initiated the investigation by interviewing first responders from the EMS, the NYPD and the ME who determined the death of the SC was not suspicious.

ACS interviewed the mother and the PS regarding the events leading up to the SC's death. According to the mother, the SC complained about feeling weak, having difficulty walking and a scratchy throat for about six days prior to her calling 911. The mother said that on 6/16/19 she checked the back of the SC's throat, and it was yellow with what appeared to be "cuts." The mother said she called 911 and once EMS arrived, the SC was transported to the hospital. The mother said the attending doctor took a culture swab and while at the hospital treated the SC for a respiratory condition and pain. The mother stated the doctor determined the SC had an infection, but had to wait for the result of the swab before prescribing an antibiotic. The doctor told the mother once he received the results, he would call in a prescription to the pharmacy. The mother said once they returned to the home, she gave the SC over the counter medication and apple sauce. According to the mother, on 6/17/19 she contacted the pharmacy and was informed that no prescription had been called in by the doctor. The mother said she then contacted the hospital and was informed the prescription would be e-mailed to the pharmacy. The mother said on 6/18/19, she received a call from the pharmacy to let her know there was an error with the dosage on the prescription. On 6/19/19, the mother picked up the prescription and gave the SC the medication on that day. The mother said the SC was unable to swallow so she chewed on the two tablets. The mother stated the SC was supposed to take the medication for 10 days, but she became disoriented after taking the first dosage, so the mother discontinued the medication. The mother reported that on 6/20/19 and 6/21/19, she did not give the SC the medication because the SC refused to eat food and the medication needed to be taken with food. The mother said she continued to monitor the SC's condition, but did not give the SC any medication. The mother said that on 6/21/19, at about 8:00 P.M. and 9:00 P.M. she checked the SC and offered her something to eat, but the SC had no appetite. The mother said she returned to check the SC at 11:00 P.M. at which time the SC was asleep. The mother said that on 6/22/19, she checked the SC at 12:00 P.M. and found the SC lying on her stomach with her "head turned, her face stuck to the sheet, and mucus coming out of the SC's mouth." The mother said she called 911 and the operator instructed her to turn the SC over, and when she did, the SC was unresponsive. The mother stated she cried and did not want to continue to touch the SC. The PS corroborated the mother's account and stated that while the mother was calling 911, he turned the SC over and suspected the SC had passed, as she was "turning stiff and her eyes rolled to the side." The PS stated the mother seemed to be in shock. When asked, the mother denied any use of drugs and explained she had been sober for the past 20 years. The mother reported she was prescribed medication for a clinical condition.

ACS contacted the school staff who reported the SC had not attended school for unknown reasons, but the mother was in constant contact with the school, notified the school whenever the SC refused to attend, and participated in 3 school conferences with the SC to address the truancy. The school staff stated the mother contacted them on 6/20/19 to report the SC was ill and on 6/25/19 reported the SC had passed. The staff stated that on 5/13/19, the SC had reported the mother had

enrolled her in clinical services. The mother corroborated the SC was enrolled in services, but had not recently attended due to her illness.

On 12/6/19, ACS indicated the report.

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: 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 investigations.

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
050561 - Deceased Child, Female, 15 Yrs	050565 - Mother's Partner, Male, 46 Year(s)	Inadequate Guardianship	Substantiated
050561 - Deceased Child, Female, 15 Yrs	050562 - Mother, Female, 51 Year(s)	Lack of Medical Care	Substantiated
050561 - Deceased Child, Female, 15 Yrs	050565 - Mother's Partner, Male, 46 Year(s)	Lack of Medical Care	Substantiated
050561 - Deceased Child, Female, 15 Yrs	050562 - Mother, Female, 51 Year(s)	DOA / Fatality	Unsubstantiated
050561 - Deceased Child, Female, 15 Yrs	050562 - Mother, Female, 51 Year(s)	Inadequate Guardianship	Substantiated
050561 - Deceased Child, Female, 15 Yrs	050565 - Mother's Partner, Male, 46 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
Pediatrician	☐	☐	☐	☒
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:
The SC's body was taken to the morgue.

There was no contact with the SC's pediatrician; however, ACS obtained relevant medical information regarding the SC's medical history.

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:
There were no surviving children in the home and the mother was receiving mental health services prior to the fatality.

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:
No surviving children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There were no immediate needs related to the fatality. ACS offered the mother funds for the funeral/burial, but she refused the offer. Also, the mother was already engaged in clinical services.

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? Yes
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

The mother had an extensive history with ACS and Family Court dating back to 1988. From 11/20/88 -6/7/11, the mother was listed as a subject in 10 indicated reports. The mother had six other children, one died in 2010 (Brain damage). Most

of the reports, with the exception of the 2011 report, involved the mother's adult children who were all adopted.

The 6/7/11 SCR report involved the SC and was indicated on 8/8/11 for IG.

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