Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-109

Prepared by: New York City Regional Office

Issue Date: Mar 12, 2018

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: 10 year(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 10/11/2017
Initial Date OCFS Notified: 10/12/2017

Presenting Information

On 10/10/17, the ten-year-old SC experienced an asthma attack while in school, he was given two treatments. On 10/11/17, the BM went to work and left the SC at home with his MU because his condition had not improved. The BM arrived home at 6:30 PM and administered a treatment; however, the SC's condition still did not improve. Later that evening, the SC was convulsing and fell unconscious and the BM initiated CPR while the MU summoned 911. The report alleged the BM did not seek medical attention in a timely manner and the SC passed away as a result. The allegations of the report were DOA/Fatality, IG and LMC of the SC by the BM.

Executive Summary

This ten-year-old male child was diagnosed with asthma since he was three months old. He experienced an asthma attack that resulted in his death on 10/12/17, while he was in the care of his BM. The SCR registered a report of his death with allegations of DOA/Fatality, IG and LMC by the BM. The final autopsy report from the ME listed the cause of death as Bronchial Asthma and the manner of death as natural.

ACS initiated the investigation in a timely manner and made contact with the appropriate collaterals which included the hospital medical staff, LE, ME, and the SC's pediatrician. ACS also interviewed the BM, MU, and a neighbor. According to the case documentation, the ACS Specialist had visited the case address earlier on the day of the incident to assess the MU due to an ongoing investigation. The Specialist observed the SC sitting on the bed receiving a treatment.

ACS learned from the BM that the SC had not been feeling well since 10/7/17 and she had been administering treatments every 4 hours daily, in addition to his medications. On 10/11/17, he stayed home because his condition had not improved. On that evening, the mother administered another treatment and two hours later, the SC fell unconscious. EMS transported him to the emergency room where he died. The BF who resides in another state had been involved with the family. He was notified of the child's death and the report.

ACS received information on 10/13/17 from the SC's pediatrician who examined, treated and released the SC on 9/14/17. The BM was given prescriptions, a pamphlet, and a follow-up appointment for one week later but she did not return. As per the Dr, the pamphlet that was given to the BM and the school, at the time of the visit, contained instructions regarding the use of the medication. The Dr explained that if after treatment, the SC did not feel better, 911 was to be summoned. The Dr stated it was inappropriate for the BM to administer medication every four hours. ACS did not ascertain whether the BM or the school staff received or read the pamphlet.

According to the case documentation, the hospital staff reported the SC was found with no signs of abuse. LE closed their case on 10/13/17 citing they found no criminality. ACS learned that the BM had no other children; however, the SC has an older sibling who resides another state with his mother. ACS made diligent attempts to locate the sibling to no avail. Based on the BM's past ACS history, there was a pattern of apprehension and delay in seeking medical intervention as she anticipated the emergency room wait time at the hospital would be too long.

On 10/12 and 10/13/17, ACS interviewed the MU who corroborated the BM's account. The MU added, on the day he stayed home with the SC, he assisted in administering the medications as instructed by the BM. The ACS Specialist notified Family Court Legal Services of the deplorable living conditions of the MU and that his whereabouts were not being supervised. As a result, on 10/12/17, an Article Ten Petition of Neglect was filed in Staten Island Family Court on

behalf of the MU against his stepmother. The court placed the MU with a family friend.

The ACS Specialist did not complete the supervisor's directives in the investigation. ACS has not yet made a determination non this investigation.

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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? N/A

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:
ACS has not yet made a determination on the investigation.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	While the Specialist made contact with appropriate collaterals such as the pediatrician, the information from the pediatrician was not fully explored to provide a thorough investigation of the allegations of the report.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/11/2017 **Time of Death:** 09:57 PM

Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: 08:52 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? Yes
How long before incident was the child last seen by caretaker? 2 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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		10 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	14 Year(s)

LDSS Response

According to ACS' documentation, on 10/10/17 the SC experienced an asthma attack while in school and was given two nebulizer treatments. The following day, the BM went to work and left the SC at home with his MU because he was not feeling well. At 6:30 PM when the BM arrived home, she woke the SC and administered a nebulizer treatment. At approximately 9:00 PM, the SC fell unconscious. The BM initiated CPR while the MU summoned 911 for emergency medical assistance. EMS transported the SC to Richmond University Medical Center (RUMC) where his death was recorded at 9:57 PM on 10/11/17.

ACS was notified of the report on 10/12/17; it alleged the BM did not seek medical attention in a timely manner and as a result the SC passed away. ACS documentation reflected there was an ongoing investigation involving the MU. The Specialist visited the case address on 10/11/17 and observed the SC in the process of receiving a treatment. ACS initiated the investigation into the death of the SC within the appropriate timeframe and the case investigation yielded the following details.

On 10/13/17, ACS learned from the office of the ME, the cause of the SC's death was Bronchial Asthma and the manner was natural. The hospital staff reported no sign of abuse was found on the SC. LE found no criminality and terminated their investigation.

According to ACS' case documentation, the BM has no other children; however, the SC has an older brother who resides with his mother in another state. The BF resides in another state and was involved in his care. The MU resides with his step-mother at another location.

The BM reported that the SC had been diagnosed with asthma since he was three months old and was prescribed a host of medications because of his condition. The SC fell ill on 10/7/17 and she filled the prescription on that day. She had been administering nebulizer treatments to the SC every 4 hours, daily.

ACS learned from the pediatrician that the SC was last examined on 9/14/17 and was prescribed new medications. The Dr explained that during the last examination, he updated the school form and a pamphlet was given to both the BM and the school with instructions regarding the new medications. The pamphlet stated that if after one treatment and 2 pumps of this medication, the SC did not feel better, 911 should be contacted. ACS' documentation did not reflect a follow-up interview with the BM with an inquiry regarding the new medication and the pamphlet. NYCRO contacted ACS regarding the need for a follow up interview regarding the information from the pediatrician.

ACS has not yet made a determination on the investigation.

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: 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
043981 - Deceased Child, , 10 Yrs	043982 - Mother, Female, 33 Year(s)	DOA / Fatality	Pending
043981 - Deceased Child, , 10 Yrs	043982 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
043981 - Deceased Child, , 10 Yrs	043982 - Mother, Female, 33 Year(s)	Lack of Medical Care	Pending

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?	☐	☒	☐	☐
School	☐	☒	☐	☐
Other	☐	☐	☐	☒
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 case documentation does not reflect that the ACS Specialist interviewed anyone from the SC's school.

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 living in the home.							

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:
The MU was provided with financial assistance, clothing, supplies in addition to placement in to the shelter system with his stepmother.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The BM declined the referral to services and was given information regarding community services. It is unknown whether she utilized the services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? 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? 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

On 10/02/2008, the SCR registered a report that alleged the parents left the hospital with the SC without having completed the much needed medical care. The allegations were IG and LMC of the SC by the parents.

ACS' investigation revealed the SC fell unconscious due to his medical condition and the BM summoned 911 for medical assistance; they were transported to the hospital. The hospital medical staff administered treatment to the SC and was in the process of admitting him when the BM left with him abruptly. LE was contacted and an ambulance transported the BF and the SC back to the hospital where the SC was treated and released. It was also revealed that the SC had been hospitalized two times previously due to his medical condition.

According to the parents, the BF had planned to take the SC back to the hospital while the BM prepare to go to work and to take the older sibling to school. The BM reported there was no hospital staff available to inform them of her plan to return.

On 12/09/08, ACS substantiated the allegations by the parents. ACS wrote that the SC was experiencing difficulty breathing and after he was triaged, the BM left the hospital despite not completing the necessary medical treatment; she placed the SC in danger. The BM was referred to a parenting class; however, it is unknown whether she completed the service.

Known CPS History Outside of NYS

There is 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