Child Fatality Report

Report Identification Number: SV-18-003

Prepared by: New York State Office of Children & Family Services

Issue Date: May 08, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 14 year(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 01/06/2018
Initial Date OCFS Notified: 01/11/2018

Presenting Information

An SCR report was received on 1/11/18 regarding the death of the SC that occurred on 1/6/18. The report alleged the SM and SF were aware the SC had been ill for five days with flu like symptoms and high fevers, that were worsening each day. The parents did not seek appropriate medical care for the SC's symptoms. As a result, the SC passed away due to pneumonia. On 1/6/18, the SF accompanied the child in an ambulance. The SF chose to drive past several hospitals, before finally stopping at a hospital when the child was no longer breathing. CPR was attempted at the hospital, but the SC did not respond and was pronounced deceased.

Executive Summary

This report concerns the death of the 14-year-old female SC. On 1/11/18, Orange County Department of Social Services (OCDSS) received an SCR report regarding the fatality. The report alleged that the SM and SF were aware the SC had worsening symptoms of illness for five days preceding her death, and they failed to seek prompt medical attention for the SC, resulting in her death. The SC was an otherwise healthy child.

The ME was contacted, but no autopsy was performed due to the family's religious beliefs. The SC died in a hospital located in New Jersey, and the ME in Orange County reviewed the SC's medical records. The death certificate was not available at the time this report was written and the cause and manner of death were not known. The physician at the hospital where the SC was taken believes the SC died due to complications of undiagnosed Leukemia, but he did not say this with certainty.

OCDSS contacted LE promptly upon receiving notification of the SC's death. LE declined to investigate because they did not feel there was any criminality involved in the fatality. LE offered to intervene in the future if OCDSS found cause to believe a crime was committed.

OCDSS learned there were six SS and they assessed the safety of the SS within 24 hours of receiving the SCR report. The SS had not been ill in the time leading up to the fatality. OCDSS consulted with the doctor treating the SC and SS, and the doctor had no concerns regarding the care the SM and SF provided to any of the children.

Throughout the course of the investigation, OCDSS requested and reviewed all the SC's medical records. The SC had received regular preventive medical care her entire life and the SM and SF followed recommendations.

OCDSS appropriately unsubstantiated the allegations against the SM and SF. The medical staff advised OCDSS the child had a serious underlying medical condition and it could have worsened quickly. There is no evidence that the SM or SF had any belief that the SC was suffering from anything other than the flu. There is also no evidence that transporting the SC to a hospital closer to her home would have saved her life.

OCDSS offered the family grief counseling services. The family declined these services, and expressed they had a tremendous amount of support from family and friends within their religious community.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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:
The case was closed appropriately.

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: 01/06/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Orange
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
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	14 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	42 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)

LDSS Response

OCDSS began the CPS investigation on 1/11/18, after receiving an SCR report regarding the death of the SC. OCDSS contacted the source, LE, the DA and the ME. The family did not consent to an autopsy due to religious beliefs, however the ME reviewed the medical records and reported there were no obvious signs of trauma or abuse noted by the attending physicians, nurses or EMS.

OCDSS went to the home of the SC within 24 hours of notification of the SC's death. OCDSS observed three of the SS (ages 16, 12 and 9) at the home. OCDSS saw the three remaining SS (ages 6, 4 and 1) at the homes of family friends. OCDSS assessed the six children were safe in the continued care of the SM and SF. None of the SS had any signs of illness. The SS were seen at subsequent home visits, but were not interviewed at the request of the parents.

The SM and SF stated that when the SC returned home from school on 1/2/18, she complained of slight dizziness and fatigue. The SF had just gotten over the flu and assumed the SC was exhibiting symptoms of the flu as well. The SF allowed the SC to stay home on 1/3/18,1/4/18 and 1/5/18 because she stated she still did not feel well. The SC was reportedly eating and drinking as usual and attended a family event the evening of 1/5/18. The SF sent the SC to bed early that evening as she was not feeling well still. On 1/6/18, the SC woke and the SF noticed her breathing was abnormal, so he called the ambulance company to transport her to the hospital. EMS arrived and the SC walked herself onto the ambulance, accompanied by the SF. EMS asked where to transport the SC and the SF told them they would know best. EMS began transit to a hospital known to have a strong pediatric unit. The SC was wearing an oxygen mask and denied any pain. About 5-10 minutes into the transport the SC began rubbing her stomach and then stopped breathing. At that point, EMS rerouted the ambulance to the closest hospital, in Hackensack, New Jersey.

EMS records indicated the SC was stable and in mild distress when they arrived. The SC reportedly had been ill with flu like symptoms in the five days preceding the call. The SC became unresponsive in the ambulance, with shallow breathing. The SC was ventilated and transported to the closest ER.

The SC's pediatrician reported she was last seen on 12/28/17 for a routine exam. The Dr. did not note any concerns in relation to her health. The SC's routine blood work indicated a Vitamin D deficiency and elevated liver enzymes. The Dr. also ordered a Complete Blood Count test that was unable to be completed that day, due to issues with the specimen collected. The Dr. was not overly concerned with the results, but wanted to repeat the tests to ensure the SC was okay. The parents had not repeated the blood tests with the SC before her death, due to her illness. OCDSS also reviewed the SS medical records and found they were all seen regularly and had up to date immunizations. The Dr. reported the SM and SF followed up as recommended.

OCDSS spoke with a pediatric attending physician at the hospital, in addition to viewing the medical records. OCDSS learned the SC tested negative for the flu, and an x-ray showed she may have had pneumonia in her lung. Based on a review of the SC's records, he believed the SC had undiagnosed Leukemia and did not think anything more could have been done to save the SC. The Dr. did not think getting the SC to a closer hospital would have changed the outcome. The Dr. stated the SC was severely ill when she arrived at the ER, and it was possible the onset of the disease was rapid. The SC's white blood cell count was extremely elevated.

OCDSS advised the BM and SF that a specialist interpreted the SC's medical records and concluded she suffered from undiagnosed Leukemia. The SM and SF agreed to bring the SS for medical testing, after OCDSS made them aware. The SM and SF denied any issues with alcohol or drugs.

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)? Yes
Comments: OCDSS notified LE and the ME of the fatality. LE did not investigate the death because there was no suspicion of criminality. The ME was available for consultation, however no autopsy was performed because of the family's religious beliefs.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045181 - Deceased Child, Female, 14 Yrs	045182 - Mother, Female, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
045181 - Deceased Child, Female, 14 Yrs	045183 - Father, Male, 44 Year(s)	Lack of Medical Care	Unsubstantiated
045181 - Deceased Child, Female, 14 Yrs	045183 - Father, Male, 44 Year(s)	DOA / Fatality	Unsubstantiated

045181 - Deceased Child, Female, 14 Yrs	045183 - Father, Male, 44 Year(s)	Inadequate Guardianship	Unsubstantiated
045181 - Deceased Child, Female, 14 Yrs	045182 - Mother, Female, 42 Year(s)	DOA / Fatality	Unsubstantiated
045181 - Deceased Child, Female, 14 Yrs	045182 - Mother, Female, 42 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐
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:

OCDSS requested to interview each of the SS, but the SF and SM would not consent to this. The SS were all assessed to be safe and OCDSS contacted their medical providers.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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? No
Explain:
OCDSS offered the SS a referral for Grief Services and the parents declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
OCDSS offered the SM and SF a referral for Grief Services and the family declined. The parents expressed the family had tremendous support from their spiritual community.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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? No
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 is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside New York State.

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