Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-23-007

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

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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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 13 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 04/05/2023
Initial Date OCFS Notified: 04/06/2023

Presenting Information

A completed OCFS-7065 Agency Reporting Form was received regarding the death of the 13-year-old subject child who was involved in an open CPS investigation. The form reflected the child died due to a severe asthma attack. The mother had left the home to pick up a medication refill for the child. The child was having trouble breathing at that time. When the mother returned, the mother and stepfather were unable to find the child's nebulizer mask and used the stepfather's continuous positive air pressure (CPAP) mask instead to administer a nebulizer treatment. The child threw up and 911 was called. The asthma attack continued to worsen in the ambulance and the child was pronounced dead on 4/5/23 at 11:18PM.

Executive Summary

This fatality report concerns the death of the 13-year-old subject child that occurred on 4/5/23. Monroe County Department of Human Services (MCDHS) learned of the child's death on 4/6/23. The fatality occurred during an open CPS investigation, which was initiated on 3/30/23 and contained allegations that the mother failed to ensure the subject child had access to her asthma medication. In addition, the mother was aware that the subject child was using marijuana and vaping, which exacerbated her asthma symptoms. At the time of the child's death, she resided with her mother, stepfather, and 17-year-old sibling. A 15-year-old stepsibling regularly visited the home, and the subject child and her sibling frequently visited their father at his residence.

The subject child required medication to control her asthma. On the evening of 4/5/23, while the mother was picking up a refill of the child's medication, the child began to experience trouble breathing. When the mother returned home, the family was unable to locate the child's nebulizer mask, and used the stepfather's CPAP mask instead. The child's symptoms did not appear to be improving following a treatment and the parents called for an ambulance. The child was transported to the hospital where she was pronounced dead at 11:18PM.

The death certificate indicated the death was referred to the medical examiner for autopsy. The manner was pending investigation at the time the death certificate was received. The record did not reflect MCDHS contacted the medical examiner or treating hospital's emergency department regarding preliminary findings or impressions. The stepfather indicated a doctor said the child likely died of cardiac arrest due to an asthma attack; however, this was not confirmed by collaterals. There was no law enforcement involvement.

MCDHS offered the family services following the fatality, which they accepted. A family services stage was opened to provide preventive services. The family was actively engaged in services when the investigation open at the time of the fatality was determined and closed.

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?** N/A
- **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:
This was not an SCR reported fatality; therefore safety assessments and a determination were not required to be recorded in Connections. The family remained open with a services case at the time this report was written.

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: 04/05/2023 **Time of Death:** 11:18 PM

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

County where fatality incident occurred: Monroe
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 and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

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	No Role	Female	13 Year(s)
Deceased Child's Household	Mother	No Role	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	17 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	45 Year(s)
Other Household 1	Father	No Role	Male	42 Year(s)

LDSS Response

At the time of the fatality, the family was involved in an active CPS investigation, initiated on 3/30/23. The investigation was regarding the subject child's asthma diagnosis and an allegation that the mother failed to ensure the child's asthma medication was filled. The event that precipitated MCDHS's involvement with the family occurred on 3/28/23, when the child experienced an asthma attack, was unable to find her medication, and requested the mother take her to the hospital. At that time the mother did not bring the child to the hospital, so the child threatened to harm herself and the mother, at which point the mother brought the child to the hospital.

MCDHS learned from the stepfather on 4/6/23 that the subject child passed away the day prior, reportedly from an asthma attack. The stepfather stated that he and the mother had come home from work and the mother had gone to refill the subject child's medication. Contact with the pediatrician confirmed albuterol was picked up on 4/5/23. The subject child reported to the stepfather that she was having trouble breathing. When the mother returned home, they were unable to locate the child's nebulizer mask, so they used the stepfather's CPAP mask. The record did not reflect which type of CPAP mask was used. The child completed a treatment and threw up. Her symptoms did not appear to be improving and the family called for an ambulance. The stepfather said the ambulance took 15 minutes to arrive. Cardiopulmonary resuscitation was attempted, and the child was transported to the hospital, where she later died. The mother was not interviewed regarding the fatal event. The sibling and stepsibling were home during the event but were directed to stay upstairs while emergency medical services were at the home.

MCDHS contacted the subject child's pediatric office, who denied concerns for the child's care and said the mother was appropriate at picking up refills and ensured the child had inhalers ordered for both parents' homes as well as school. The child was last seen for an asthma check-up in 2/2023 and her record indicated multiple emergency department and urgent care visits for asthma exacerbation. Attempts to speak directly with the child's pediatrician were unsuccessful. There was no additional medical information obtained regarding the fatal incident.

All family members expressed an interest in grief counseling services. The mother, stepfather, and sibling's household were provided preventive services and the case remained open at the time this fatality report was written. The stepsibling was engaged in services through that household as well. The father expressed interest in counseling; however, it was unknown if he was referred.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
Other	☐	☐	☐	☒
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The record reflected EMS responded to the home, the child was pronounced deceased at the hospital, and an autopsy was performed; however, contact with these collaterals was not documented.

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 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?				

Explain:
This was not an SCR reported fatality, therefore Safety Assessments were not required to be documented at the specified intervals in Connections. MCDHS did assess the surviving sibling and stepsibling and both were assessed to be safe in their parents' care.

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Preventive Services							

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:
A preventive services case was opened with the mother, stepfather, and 17yo sibling. The 15yo stepsibling was involved in these services at times as well. Services focused on processing grief, coping skills, and processing trauma.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The preventive services case involved the mother and stepfather; however, the service plan focused on the 17yo sibling's service needs. It was unknown if either the mother, stepfather, or father were referred to or engaged in bereavement specific services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? No

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)

03/30/2023	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Childs Drug / Alcohol Use	Unsubstantiated	No
	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 13 Years	Mother, Female, 36 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report was received 3/30/23 which alleged the SC had severe asthma requiring medication. The BM was aware and failed to ensure the medication was available. The SC was using marijuana and vaping, which impacted her asthma. The BM was aware and failed to intervene. On 3/28/23, the SC had an asthma attack, could not find her medication, and requested to go to the hospital. The BM refused, so the SC threatened to harm herself and the BM. Due to the SC's threats, the BM brought the SC to the hospital.

Report Determination: Unfounded | **Date of Determination:** 06/30/2023

Basis for Determination:
MCDHS unfounded the report. Collateral contact with medical providers showed the SC had received care on an emergent basis multiple times for the exacerbation of asthma symptoms. The SC was last seen by her pediatrician in 2/2023 for asthma and the pediatrician reported no concerns regarding the parents and reported the mother was appropriate at picking up medication refills and having inhalers on hand. The mother reported the SC displayed specific symptoms when experiencing an asthma attack, which the SC did not display during that event. The SC's last medication refill was on 3/18/23 and should have lasted 30 days.

OCFS Review Results:
MCDHS initiated their investigation timely, contacted the source of the report, and conducted a CPS history check. The subject child received a psychiatric evaluation due to her behaviors and while those records were received, treatment records in response to any medical intervention because of asthma symptoms were not requested. It was not documented that the child's medication had been refilled or was on hand. The child's father was spoken to and denied concerns for the child's care. While aware of the child's marijuana and vape use, no adult condoned the use or knew how the child obtained the items.

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

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

In 2012, MCDHS substantiated allegations of Inadequate Guardianship and Sexual Abuse against the mother's paramour at the time, regarding the subject child. The child was referred to counseling and a family services stage was opened.

In 2013, MCDHS unsubstantiated allegations of Inadequate Guardianship, Lacerations/Bruises/Welts, and Sexual Abuse against the subject child's grandparents, regarding the subject child.

In 2017, MCDHS unsubstantiated the allegations of Other against the mother and father in response to a court ordered investigation precipitated by a custody/visitation modification petition regarding the subject child and sibling.

In 2018, MCDHS unsubstantiated allegations of Inadequate Guardianship and Lack of Medical Care against the mother and father regarding the subject child. The report had alleged concerns that the mother and father did not pick up the child's nebulizer medication and had left the hospital against medical advice; however, the investigation concluded that the parents had the proper medication on hand, followed up with appropriate providers, and followed the prescribed treatment plan.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A preventive services case was opened with the mother, sibling, and subject child in 6/2012 in response to the sexual abuse allegations made by the subject child. Services focused on providing education on sexual abuse dynamics and recognizing signs and types of behavior that may arise because of experiencing sexual abuse. The record reflected the mother had gained coping skills, decreased stress, and increased her knowledge around sexual abuse and was able to protect the children from further abuse. The subject child had learned about safe and unsafe touch. In 7/2012 it was learned the sibling and subject child were to spend the summer with their father and the case was closed. There were no reported behavior concerns with the subject child at the time of case closing.

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