Child Fatality Report

Report Identification Number: SV-18-008

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

Issue Date: Jun 15, 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: 15 year(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 01/26/2018
Initial Date OCFS Notified: 01/27/2018

Presenting Information

An SCR report was received regarding the death of the SC. The report stated the 15-year-old SC experienced a headache on 1/26/18 in addition to having medical needs for which he received regular treatment. The SM checked on the SC at 9:00PM and the father's roommate (OA) saw SC later at around 9:30PM. At 10:45PM the SF checked on the SC and found him unconscious. The SC was taken to the ER and his death pronounced at 11:49PM.

Executive Summary

This report concerns the death of the 15-year-old male SC. Westchester County Department of Social Services (WCDSS) received an SCR report regarding the SC's death on 1/27/18. The SC had recently been experiencing headaches. The cause of the SC's death was unknown, therefore the SM, SF and OA were considered subjects in his death.

On 1/26/18 the SC had a headache when the SM visited the SC at the SF's home and found his blood sugar levels to be high. The SM wanted to take the SC to the ER for a medical evaluation, but the SC refused to go. The SM left the SC and returned to her home. The SF was at work during this time. The OA arrived at the SF's home where he also resided, just as the SM was leaving. The SC went into his bedroom and the OA went into the bathroom to bathe. The SF arrived home from work later in the evening and found the SC unresponsive. The SF called for EMS and notified the SM.

The DA was notified. LE investigated and found no suspicion that abuse or maltreatment led to the death of the SC. LE attributed the SC's death to medical complications and no criminal charges were pursued. The ME performed an autopsy, but the final report was not complete at the time this report was written. The ME reported that the SC had some fluid on his brain, but it was not clear if the fluid had an impact on the SC's death. WCDSS was advised the family reported that the SC had a headache and was vomiting in the 2 days preceding his death.

WCDSS contacted several medical professionals and learned the SM and SF had not followed through on recommended medical interventions in regard to the SC's weight and diet. The SM and SF did not adhere to a nutrition plan for the SC and the SC refused to go to follow up appointments. It is unclear if this contributed to his death. WCDSS expressed their concerns that the SM and SF did not adequately attend to the medical needs of the SC and instead allowed him to make his own decisions.

WCDSS spoke in depth with the SM and SF regarding following through on medical appointments and testing, as well as education concerns that arose during the investigation, regarding the SS. The parents were receptive to WCDSS suggestions. The SS were both seen and interviewed multiple times throughout the investigation, and assessed to be safe.

WCDSS unsubstantiated the allegations against OA because they appropriately determined he was not a caretaker for the SC. The allegations of DOA/Fatality against the SM and SF were unsubstantiated as WCDSS found no evidence to suggest a correlation between the SC's death and the parents failing to take the SC for immediate medical attention. WCDSS added an allegation of LMC and substantiated this allegation, along with IG against the SM and SF regarding the SC. WCDSS found evidence that the SC was vomiting and had a persistent headache in the days leading up to his death. The SM and SF argued over who would take the SC for treatment and consequently the SC was never taken to the ER. The SM and SF failed to exercise a minimum degree of care when they failed to get medical attention for the SC.

WCDSS offered the SM, SF, and SS bereavement/mental health counseling and education evaluation services. A referral was also made for Victims Assistance Services.

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:
All concerns that arose during the investigation were appropriately addressed.

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: 01/26/2018 **Time of Death:** 11:49 PM

Time of fatal incident, if different than time of death: 10:45 PM

County where fatality incident occurred: Westchester

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? 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	Male	15 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	41 Year(s)
Deceased Child's Household	Other Adult - father's roommate	Alleged Perpetrator	Male	44 Year(s)
Other Household 1	Mother	Alleged Perpetrator	Female	37 Year(s)
Other Household 1	Sibling	No Role	Male	6 Year(s)
Other Household 1	Sibling	No Role	Male	13 Year(s)
Other Household 2	Stepfather	No Role	Male	37 Year(s)

LDSS Response

On 1/27/18 WCDSS received an SCR report regarding the death of the SC. WCDSS immediately contacted the source of the report, the DA, LE and completed a CPS history review for the family. WCDSS made immediate attempts to contact and interview the family, but the family was distraught with grief, and agreed to a meeting with WCDSS on 1/31/18.

The SM explained the SC had gone to live with the SF on 12/29/17, while the SS (ages 6 and 13) remained in the SM's home. The SF was also the father of the 13yo SS. The SC was reportedly healthy while residing with the SM and SF. The SM regularly visited and spoke with the SC. The BF of the 6yo SS did not reside in the SM's home, but had regular contact with the SS.

The SC had been treated for a medical condition since infancy. The SM reported that the SC saw a doctor to monitor the condition and there were no concerns in the time leading up to the SC's death. The SC was not prescribed any medication. On 1/25/18, the SC complained his head hurt a little. The SM gave the SC 2 ibuprofen to ease his pain. The SM denied the SC regularly complained of pain. Later in the evening of 1/25/18, the SM dropped the SC off at the BF's home. On 1/26/18 the SM spoke with the SC at about 9:00PM and he reported he still had a headache. The SF was working on the evenings of 1/25/18 and 1/26/18, but was aware the SC had a headache. The SM visited the SF's home at about 8:50PM on 1/26/18 and asked the SC to come outside; the SC sat in the SM's car while she checked his blood sugar. The SC's levels were high and the SM told him she wanted to bring him to the ER. The SC refused to go, stating he was feeling better, and he went

back into the SF's home.

WCDSS interviewed the OA and learned he rented a room in the SF's home and was home on 1/26/18 when the SC was home. OA reported he saw the SC get out of the SM's car and go into the house, to his bedroom. OA went to his room and then took a shower. OA reported the SF knocked on the door a short while later, but OA continued bathing. When OA came out of the bathroom, EMS was already at the home attempting resuscitation efforts on the SC. OA had no further information regarding the death of the SC and reported the SC and SF had a loving relationship.

The SF told WCDSS he arrived home from work at about 10:45PM on 1/26/18. He went into the bedroom he shared with his son, and found the SC lying on the floor. The SF tried to pick up the SC and move him, but the SC was unresponsive. The SF called 911 and EMS arrived and began CPR. The SF called the SM and the SM arrived at the home minutes later. After about 45 minutes of efforts, EMS was unable to resuscitate the SC and transported him to the ER. LE was at the home interviewing the SM, SF and OA. The SM went to the ER to be with the SC.

The SC's doctor reported concerns regarding the SC's nutrition and weight, and the SM and SF did not follow through with medical appointments as recommended. The SC was last seen by the Dr. on 7/28/16. WCDSS spoke with the SM and SF regarding these concerns and the SM reported the SC refused to continue going to the medical appointments, so she gave up on trying to get him to go.

The SS were interviewed and assessed to be safe. The 13yo SS stated the SC had complained of a headache and been vomiting the day before his death. The SM told the SC she was bringing him to the ER, but the SC refused to go.

The Dr. reported the SS were up to date on immunizations, but needed follow up medical appointments. WCDSS contacted the schools for the SS and spoke with the SM and SF about the educational recommendations for the SS. The SM, SF and BF of the SS agreed to follow through with medical and educational recommendations regarding the SS.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

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
046141 - Deceased Child, Male, 15 Yrs	046144 - Mother, Female, 37 Year(s)	Lack of Medical Care	Substantiated
046141 - Deceased Child, Male, 15 Yrs	046144 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
046141 - Deceased Child, Male, 15 Yrs	046142 - Father, Male, 41 Year(s)	Inadequate Guardianship	Substantiated

046141 - Deceased Child, Male, 15 Yrs	046142 - Father, Male, 41 Year(s)	DOA / Fatality	Unsubstantiated
046141 - Deceased Child, Male, 15 Yrs	046143 - Other Adult - father's roommate, Male, 44 Year(s)	DOA / Fatality	Unsubstantiated
046141 - Deceased Child, Male, 15 Yrs	046144 - Mother, Female, 37 Year(s)	DOA / Fatality	Unsubstantiated
046141 - Deceased Child, Male, 15 Yrs	046142 - Father, Male, 41 Year(s)	Lack of Medical Care	Substantiated
046141 - Deceased Child, Male, 15 Yrs	046143 - Other Adult - father's roommate, Male, 44 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?	☒	☐	☐	☐

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Education Evaluation							

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? 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

5/19/08-An SCR report with allegations of B/S and IG Unsub against the BM regarding the SC.
4/1/09-An SCR report was tracked to FAR with the allegations of LMC and EdN.
9/21/09-An SCR report with allegations of XCP and L/B/W Unsub against the BM regarding the SC.

Known CPS History Outside of NYS

There is no known CPS history outside of 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