Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-039

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

Issue Date: Dec 22, 2023

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: 5 year(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 07/14/2023
Initial Date OCFS Notified: 07/20/2023

Presenting Information

An SCR report was received on 7/20/23 and alleged the father and the mother were not providing adequate food for the 5-year-old subject child and the 13 and 17-year-old surviving siblings. The children were going without meals on a consistent basis. As a result of inadequate food, the subject child died of malnutrition on 7/14/23.

Executive Summary

This report concerns the death of a 5-year-old female child that occurred on 7/14/23. Orange County Department of Social Services (OCDSS) received an SCR report on 7/20/23, regarding the fatality. The report contained allegations of DOA/Fatality, Inadequate Guardianship, Inadequate/Food/Clothing/Shelter and Malnutrition/Failure-to-thrive against the mother and father of the subject child. In addition, the report contained allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter against the mother and father regarding the 13, 15 and 17-year-old surviving siblings. At the time of her death, the subject child resided with her mother, father, and siblings. The siblings ranged in ages from 9, 15, 17 and there were twin 11 and twin 13-year-olds. OCDSS immediately initiated their investigation and learned there were seven surviving siblings who were assessed to be safe in their parents' care.

Through a joint investigation with law enforcement, it was learned on 7/14/23, the subject child was at her family's residence and was displaying symptoms of being ill. The father observed the child did not look well and called for a taxi to transport her to the pediatrician's office. While in route to the pediatrician's office, the subject child went into medical distress. Emergency Medical Services were contacted and advised the father to continue to the pediatrician's office where they would meet the family. Upon arrival, the subject child was rushed into the office with no pulse. Resuscitative efforts were made for sixty minutes; however, were unsuccessful. The subject child was pronounced deceased at 3:45PM. The subject child was buried immediately following the death due to religious customs and an autopsy was not performed. OCDSS communicated with law enforcement and learned there were no concerns for abuse or maltreatment and there were no criminal charges against the parents.

OCDSS communicated with the pediatrician who pronounced the child deceased. The pediatrician explained there were no signs of trauma to the child or suspicious injuries, and he denied any concerns for malnourishment. An autopsy was not performed; however, the child's certificate of death listed the immediate cause of death as cardiopulmonary arrest due to electrolyte imbalance as consequence of vomiting and gastroenteritis.

OCDSS unsubstantiated all the allegations referenced above against the mother and father. Safety and risk assessments were completed timely and accurately. Progress notes were entered contemporaneously, and all required notifications were provided. In addition, OCDSS gathered pertinent information from collateral contacts and utilized interpreter services to assist with any language barriers.

OCDSS discussed their ability to refer the family for counseling services; the parents did not accept. The parents were open to discussing what counseling services the school district could offer. The community liaison was also assisting the family with enrolling in mental health services. In addition, preventive services were offered to the family which the parents declined.

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

Explain:
OCDSS made an appropriate decision to unsubstantiate the allegations based on evidence obtained throughout their investigation.

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:
Casework activity was commensurate with case circumstances.

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: 07/14/2023 **Time of Death:** 03:45 PM

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 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	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	46 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	15 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	13 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)

LDSS Response

On 7/20/23, OCDSS received an SCR report regarding the death of the SC. OCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. OCDSS contacted the source of the report, reviewed prior CPS history, and notified the district attorney and medical examiner. OCDSS immediately assessed the surviving siblings to be safe in the home and in the care of their parents.

On 7/20/23, OCDSS interviewed the pediatrician regarding the fatality. During his interview, he explained the SC was treated at the pediatrician's office on 7/2/23, 7/12/23 and the day of her death on 7/14/23. Prior to those visits, the pediatrician reported he had not treated the SC or any of her siblings. On 7/2/23, the SC was diagnosed with a bacterial infection and prescribed Zithromax. On 7/12/23, she was treated for abdominal pain which was assessed to be constipation. The pediatrician advised the parents to use miralax or mineral oil and if the child was in servere pain, the parents were directed to give an enema. On 7/14/23, he explained the SC was rushed into his office by the SF who was holding the child in his arms and yelling CPR. When the SC arrived, she had no pulse, and her veins were inaccessible. The pediatrician attempted to resuscitate the SC for an hour; however, all attempts were unsuccessful, and she was pronounced deceased at 3:45PM. The pediatrician reported there were no signs of trauma or suspicious injuries to the SC. In addition, he explained the SC's height, weight and BMI were within appropriate limits and he did not feel the SC was

malnourished.

OCDSS interviewed the SF on 7/20/23 and 7/21/23 regarding the fatality. During his interview, he explained on 7/14/23, he arrived home from work and observed the SC did not look well. He immediately called a taxi and contacted the pediatrician who had recently seen the SC. The pediatrician agreed to see the SC and advised the SF to bring her into the office. When the taxi arrived, the SC was awake and able to hold her head up; however, shortly after leaving the home she became unresponsive. The SF contacted EMS while being transported and they advised the SF to continue to the pediatrician's office. Upon arrival, the SF carried the SC into the office where the pediatrician attempted live-saving efforts. The SF denied any medical concerns for the SC other than her recent diagnosis of a bacterial infection on 7/2/23. The SF confirmed the SC was seen at the pediatrician on two occasions prior to her death.

OCDSS interviewed the SSs with law enforcement at a Child Advocacy Center. All the siblings were screened for poly victimization and denied any concerns for their parents as well as the home. The children also reported having sufficient food. OCDSS requested the siblings obtain updated physicals which were completed on 7/25/23 and there were no concerns for their physical health.

OCDSS interviewed the SM on 7/28/23 regarding the fatality. During her interview, the SM confirmed the SC was seen on 7/2/23, 7/12/23, her recent diagnoses of bacterial infection and constipation as well as recommended treatment. The SM explained after the 7/12/23 visit, the parents gave the SC an enema and she appeared to feel better. She reported the SC was eating and drinking but it was minimal, and the SC spent most of her time in bed or laying on the couch. On 7/13/23, the evening prior to the fatality the SC was complaining of being in pain. The SM believed that the SC was still constipated as that was what she was diagnosed with on 7/12/23. The SM confirmed the SF took the SC to the pediatrician on 7/14/23 when he arrived home from work.

OCDSS communicated with collaterals within the community such as the pediatrician, medical providers, the taxi service, the school district, and a liaison for the religious community. All collaterals denied concerns for the parents.

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: The child's pediatrician

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Orange County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065508 - Deceased Child, Female, 5 Year(s)	065509 - Mother, Female, 41 Year(s)	DOA / Fatality	Unsubstantiated
065508 - Deceased Child, Female, 5 Year(s)	065509 - Mother, Female, 41 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065508 - Deceased Child, Female, 5	065509 - Mother, Female, 41	Inadequate Guardianship	Unsubstantiated

Year(s)	Year(s)		
065508 - Deceased Child, Female, 5 Year(s)	065509 - Mother, Female, 41 Year(s)	Malnutrition / Failure to Thrive	Unsubstantiated
065508 - Deceased Child, Female, 5 Year(s)	065510 - Father, Male, 46 Year(s)	DOA / Fatality	Unsubstantiated
065508 - Deceased Child, Female, 5 Year(s)	065510 - Father, Male, 46 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065508 - Deceased Child, Female, 5 Year(s)	065510 - Father, Male, 46 Year(s)	Inadequate Guardianship	Unsubstantiated
065508 - Deceased Child, Female, 5 Year(s)	065510 - Father, Male, 46 Year(s)	Malnutrition / Failure to Thrive	Unsubstantiated
065511 - Sibling, Male, 17 Year(s)	065509 - Mother, Female, 41 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065511 - Sibling, Male, 17 Year(s)	065510 - Father, Male, 46 Year(s)	Inadequate Guardianship	Unsubstantiated
065511 - Sibling, Male, 17 Year(s)	065509 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Unsubstantiated
065511 - Sibling, Male, 17 Year(s)	065510 - Father, Male, 46 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065512 - Sibling, Female, 15 Year(s)	065510 - Father, Male, 46 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065512 - Sibling, Female, 15 Year(s)	065509 - Mother, Female, 41 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065512 - Sibling, Female, 15 Year(s)	065509 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Unsubstantiated
065512 - Sibling, Female, 15 Year(s)	065510 - Father, Male, 46 Year(s)	Inadequate Guardianship	Unsubstantiated
065514 - Sibling, Male, 13 Year(s)	065509 - Mother, Female, 41 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065514 - Sibling, Male, 13 Year(s)	065510 - Father, Male, 46 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
065514 - Sibling, Male, 13 Year(s)	065509 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Unsubstantiated
065514 - Sibling, Male, 13 Year(s)	065510 - Father, Male, 46 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?	☒	☐	☐	☐
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 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 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	☐	☐	☐	☐	☐	☒	☐

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:
OCDSS and a community liaison offered to assist with counseling services for all family members on multiple occasions. At the time this report was written, it was unknown if the family engaged in counseling services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS and a community liaison offered to assist with counseling services for all family members on multiple occasions. In addition, OCDSS offered the family preventive services which the family declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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

On 11/9/14, the Administration for Children's Services received an SCR report against the mother and father and substantiated allegations of Inadequate Guardianship regarding all the surviving siblings. Allegations of Inadequate Food/Clothing/Shelter were unsubstantiated against both parents regarding all the siblings. In addition, allegations of Lack of Supervision were unsubstantiated against the mother and father regarding the then twin 4-year-old siblings. The investigation was closed on 1/6/15.

On 10/5/15, Sullivan County received an SCR report against the mother and father and unsubstantiated the allegation of Inadequate Guardianship and Lack of Supervision regarding the then 9-year-old, 7-year-old, twin 5-year-old and twin 3-year-old siblings. The then 1-year-old sibling was listed as no role. The investigation was closed on 1/11/16.

Known CPS History Outside of NYS

There is no known CPS 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