Child Fatality Report

Report Identification Number: NY-22-044

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

Issue Date: Nov 17, 2022

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	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		

Case Information

Report Type: Child Deceased
Age: 7 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/11/2022
Initial Date OCFS Notified: 06/11/2022

Presenting Information

An SCR report alleged on 6/10/22, the 7-year-old subject child returned home from attending a school field trip and complained of a headache and being hot during the trip. On 6/11/22, at an unknown time, the child woke up and began vomiting. The mother took the child's temperature and determined the child had a fever. The mother gave the child Motrin sometime before 3:00 PM. At 3:00 PM, the child fell asleep. At 8:00 PM, the mother tried to wake the child but was unsuccessful. The mother contacted EMS, who responded to the home and found the child unresponsive. The child was transported to the hospital where she was pronounced deceased at 10:00 PM.

Executive Summary

This report concerns the death of the 7-year-old child that occurred on 6/11/22. A report was made to the SCR on the same day alleging the child passed away after having a headache and feeling hot during a school field trip. At the time of her death, the child resided with her parents and 2-year-old sibling. The sibling was assessed to be safe in the care of the parents.

The Administration for Children Services (ACS) attempted to coordinate investigative efforts with law enforcement upon receipt of the SCR report. The district attorney’s office provided information that law enforcement closed their investigation without criminal charges. An autopsy was performed; however, the final autopsy was not available at the time this report was written. The medical examiner preliminarily stated the manner of death was natural and he did not have reason to believe the death was a result of abuse or maltreatment. The medical examiner noted it was possible the child died due to a bacterial infection.

The parents stated the child went on a school field trip on 6/10/22, and when she returned, she complained of a headache. The child ate normally throughout the day and evening. The following afternoon, the child again complained of a headache, and she vomited. Later in the day, the family took a nap together. When they awoke, the child had a rash on her face. Due to the child’s preexisting condition, the mother called the hospital; however, they were asking too many questions, so the mother ended the call and dialed 911. The child was transported to the hospital where she was pronounced deceased.

ACS gathered information from hospital staff, the hematologist, family members and the school. There were no concerns for the care the parents provided to the child or the sibling.

Home visits were made, and the safety of the sibling was thoroughly assessed. Although completed timely, the Safety Assessments were completed inaccurately.

The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated. The investigation revealed the parents were compliant with the child’s medical appointments with her pediatrician and specialist. The parents acted appropriately and sought medical care for the child when she was in medical distress.

ACS offered the family bereavement services, mental health counseling referrals and burial assistance. The family accepted the services, and the case was closed timely.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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?** No

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:
The Safety Assessments reflected there was a safety factor as the sibling had a medical condition; however, the parents were adequately providing medical care to the child and therefore, the safety factor should not have been selected.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The Safety Assessments were completed inaccurately as they were completed with regard to risk. There were no safety factors identified for the sibling.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The Safety Assessments were completed inaccurately as they reflected the parents were unwilling or unable to provide care for the sibling's medical condition; however, progress notes reflected the sibling received adequate care.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/11/2022 **Time of Death:** 10:00 PM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:21 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: Unconscious

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	7 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 6/11/22, ACS received the fatality report from the SCR. Within the first 24 hours of the investigation, ACS contacted the source of the report, hospital staff, and contacted law enforcement. The district attorney and medical examiner's offices were made aware of the death, and a CPS history check was documented.

The hospital doctor explained that on the day of the child's death, she complained of a headache, felt weak and napped but did not feel better so the parents sought medical attention. The doctor provided information that the child had an inherited blood disorder and was septic upon her arrival at the hospital. According to the doctor, the death was unavoidable and was

in no way the fault of either parent.

On 6/13/22, ACS held a video conference with the parents and the sibling was assessed to be safe. The parents stated the child had a blood disorder for the entirety of her life. On 6/14/22, the parents were interviewed face-to-face. Information was gathered that due to the child's medical condition, she was unable to quickly transition from different temperature environments as her blood would clot. The mother reported on 6/10/22, the child went on a field trip with her school. The child ate normally on the trip and returned home. Around 8:00 PM, the child said she was tired and that she had a headache. On 6/11/22, the child again reported she had a headache, and she vomited. Shortly thereafter, the mother noticed the child had a rash on her face. The mother called the hospital; however, staff was asking too many questions, so the mother ended the call and contacted 911. The mother noticed the child's hand was clenched and that the rash had spread on to the child's feet. The child's eyes rolled back, and she fell unconscious. EMS responded to the home and transported the child to the hospital. The father said the child was frequently hospitalized due to her disorder and that she required daily medications. The father described 6/10/22 to be a normal day for the child and to his knowledge, the child did not have any signs of illness or distress. When she woke around 9:00 AM on 6/11/22, she appeared fine; however, in the afternoon, the child was holding food in her mouth and would not swallow it. The child walked normally to the bathroom, and she vomited. Around 8:00 PM, the mother noticed the child's rash and called 911. The father did not have additional information. The sibling was observed and was unable to be interviewed due to her age.

ACS interviewed the paternal grandfather who was aware the child went on a school field trip on the day prior to her death, and when she returned home, she complained of a headache. The mother gave her medicine, and the child went to bed. The grandfather did not have additional information.

ACS gathered collateral information from the child's school, pediatrician, and the hematologist. The school staff reported the parents were involved and the mother prioritized the child's needs; however, ACS was unable to gather information regarding the child's demeanor on the field trip, despite attempts to speak with the child's teacher. The pediatrician did not have concerns for the child's medical care. The hematologist stated the child received adequate care and that her medical condition was under control. The hematologist described the mother as reliable and said she was compliant with appointments and treatment.

ACS conducted a thorough investigation into the death. After all required casework activities were completed and the family was not in need for further intervention from ACS, ACS appropriately determined and closed the investigation.

Official Manner and Cause of Death

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

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?No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

061871 - Deceased Child, Female, 7 Yrs	061872 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
061871 - Deceased Child, Female, 7 Yrs	061872 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
061871 - Deceased Child, Female, 7 Yrs	061873 - Father, Male, 32 Year(s)	DOA / Fatality	Unsubstantiated
061871 - Deceased Child, Female, 7 Yrs	061873 - Father, Male, 32 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?	☒	☐	☐	☐

Additional information:

ACS attempted to coordinate the investigation with law enforcement; however, law enforcement did not participate and closed their investigation.

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	☒	☐	☐	☐
Explain: The parents accepted bereavement services.				

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?	☐	☒	☐	☐
Explain as necessary: The sibling did not need to be removed from the care of the parents.				

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:
The sibling was too young to benefit from bereavement services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered mental health therapy, bereavement counseling and funeral assistance. The services were accepted.

History Prior to the Fatality

Child Information

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

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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