NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-16-018 **Prepared by: Spring Valley Regional Office**

Issue Date: 10/24/2016

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 13 year(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 05/31/2016
Initial Date OCFS Notified: 06/01/2016

Presenting Information

A report was made to the New York Statewide Central Register of Child Abuse and Maltreatment on 6/1/2016, which alleged DOA/Fatality and Inadequate Guardianship regarding the mother on behalf of the 13-year-old male subject child. This report alleged on 5/30/16 a urine test was done at home and the subject child's ketones were found to have been unbalanced. On 5/31/2016, the subject child stayed home from school complaining of a headache. The mother allegedly left for work and was unsuccessful at reaching the subject child through phone calls throughout the day. Approximately 10 hours later, the mother returned home and found the subject child dead on a bedroom floor. The mother provided the subject child with a shot at that time; however this was unsuccessful in changing his status. The subject child had a pre-existing medical condition of Diabetes. At the time the report was made, the cause of death was unknown.

Executive Summary

The investigation revealed that the subject child was diagnosed with insulin dependent Diabetes in July 2010, and he began to have many medical issues associated with his condition. He was in and out of the hospital as his diabetes was not regulated. He was prescribed a Diabetic pump to help with his insulin input, however this was taken out when the subject child was 13-years-old as the pump was said to often malfunction causing an insulin imbalance. On 5/31/2016, the subject child woke up, and complained of a headache and had a ketone imbalance in his urine output the night before. The mother told the subject child that he could remain home after checking his glucose levels and administering the appropriate medications. The subject child was said to have not eaten anything prior to the mother leaving the home around 6:55 AM, so the mother provided him with the appropriate dosage of medicine for the subject child to administer in the event he ate. The mother called the home several times in an effort to reach the subject child, and did not receive an answer. The mother stated that she informed the subject child on a previous occasion the importance of answering the telephone when he is home alone, and he agreed to do so. At approximately 6:00 PM, the mother returned to the home from work and found the subject child on the bedroom floor and his lips were blue. The mother began to administer CPR to the subject child, gave him a shot of his medication, and called 911. The subject child had rigor to the jaw and fingers and his skin was moist, cool and cyanotic upon discovery. The fatality time was listed as 5/31/2016 at 18:30PM.

Medical records indicated the subject child and mother struggled to control the subject child’s glucose levels and had a history of decreased supervision of insulin dosing and missed/gaps between appointments. A Certified Diabetes Educator was assigned to work with the family in regard to the subject child’s diabetes however it was noted a “wall” existed with trying to educate the family on carbohydrate counting. Concerns were also noted with the subject child’s glucose levels being inconsistent and Hyperglycemia instances were noted. Concern was also noted in regard to the subject child falsifying his blood sugar numbers to the school nurse, and being non-compliant with his diet and not monitoring his glucose levels. Records also indicate the subject child was brought to the emergency department for Diabetic Ketoacidosis in the past.

The final Autopsy Report revealed the Medical Examiner’s determination that the subject child’s cause of death was

diabetic ketoacidosis. The manner of death deemed natural.

The allegation of Medical Neglect was added to the report and substantiated regarding the mother on behalf of the subject child. The allegation of Inadequate Guardianship listed on the report was also substantiated regarding the mother on behalf of the subject child. The allegation of DOA/Fatality regarding the mother on behalf of the subject child was unsubstantiated as WCDSS found no evidence to support the maltreatment or neglect on behalf of the mother. During the investigation, the mother relocated to Georgia to be closer to relatives. Victims Assistance Services were offered to the mother to include bereavement services and financial assistance for the subject child's funeral and declined. Referrals for services in Georgia were also offered to the mother however; were also declined. There were no surviving siblings or other minor children residing in the home. The CPS investigation was closed on 7/29/2016.

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?** 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:
All assessments and the decision to close the case as indicated were appropriate.

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 decision to close the case was appropriate.

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: 05/31/2016 **Time of Death:** 06:30 PM

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

County where fatality incident occurred: WESTCHESTER
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to 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 - but needed
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	13 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)

LDSS Response

Westchester County Department of Social Services, (WCDSS), conducted an investigation into the allegations listed on the report. WCDSS made appropriate collateral contacts including the Medical Examiner, local law enforcement officials, medical professionals, relatives, and community resources. The subject mother was interviewed and observed, and the allegations were discussed. Appropriate service referrals were offered to the family; however declined.

There were no surviving siblings or other minor children residing in the home. WCDSS completed all safety assessments and the risk assessment profile (RAP) accordingly. The case notes were well documented, detailed, and contemporaneous.

As per the Medical Examiner's office, an autopsy was performed on the subject child. The final Autopsy Report revealed the Medical Examiner's determination that the subject child's cause of death was diabetic ketoacidosis. The manner of death deemed natural. It was noted that the subject child was diagnosed with Diabetes in 7/10, and had complications from not being appropriately monitored and was in and out of the hospital because his glucose levels were not regulated. The allegation of Medical Neglect was added to the report as there was a history of the mother not following up with medical appointments, allowing a large gap in between appointments, and not following the recommendations of medical

professionals.

There was documentation of supervisory conferences noted in which the circumstances of the case were discussed and directives were provided.

The allegation of Inadequate Guardianship and Medical Neglect were substantiated regarding the mother, on behalf of the subject child. The mother left the subject child alone and unattended for an extended period of time knowing that he was not feeling well and his ketone and glucose levels being abnormal. The mother attempted to reach the subject child via phone and was unsuccessful despite having discussed the importance of answering the phone with him prior. The mother did not return to the home until approximately 11 hours later, and denied returning to the home, or asking for assistance with checking on the subject child despite knowledge of the subject child's ongoing health challenges and his history of non-compliance of medications and diet when unsupervised. The allegation of DOA/Fatality regarding the mother on behalf of the subject child was unsubstantiated as no causal connection could be established. Appropriate service referrals were provided to the family for Victims Assistance Services that included both bereavement counseling and burial assistance, however were declined. It was also documented that the VAS worker provided referrals for the mother to engage in services in Georgia where she relocated to, during the course of the investigation. The CPS investigation was closed on 7/29/2016.

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: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: The fatality investigation was conducted by an MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: An OCFS approved Child Fatality Review Team meeting was held on 6/13/2016 in regard to this case.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
030401 - Deceased Child, Male, 13 Yrs	030402 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
030401 - Deceased Child, Male, 13 Yrs	030402 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
030401 - Deceased Child, Male, 13 Yrs	030402 - Mother, Female, 34 Year(s)	Lack of Medical Care	Substantiated

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?	☐	☒	☐	☐

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	Needed but not Offered	Needed but Unavaliable	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: Victims Assistance Services							
Additional information, if necessary: Victims Assistance Services were offered to the mother and declined. Service referrals were also provided to the mother for when she relocated to Georgia, however she declined those services as well.							

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? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Victims Assistance Services were offered to the mother and relatives, however declined. Services referrals were also made for the mother upon her re-location in Georgia, however; she declined these services as well.

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?	N/A
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 within three years prior to the fatality.

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

A case was reported to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) on 1/4/2008 alleging Swelling, Dislocation, Sprains and Inadequate Guardianship regarding the mother on behalf of the subject child. This report alleged the subject child was punched in the eye by his mother causing swelling because he did not do his homework. Upon further investigation, it was determined the subject child hit himself on the refrigerator door by accident after bending over to pick up a pencil. The subject child explained that he was disciplined by having his television privileges taken away. As per Medical Professionals, the subject child's injury did not appear to have been consistent with being punched. The allegations listed on the report were determined to have been unsubstantiated. The family declined services and the case was closed on 3/6/2008.

There was also a reported case called into the SCR on 3/15/13 alleging Lack of Medical Care and Inadequate Guardianship regarding the mother on behalf of the subject child. The case was assigned to the FAR track, and closed on 5/21/2013 as it was determined the family was no longer in need of FAR services.

Known CPS History Outside of NYS

The family had history with the Department of Children and Family Services in Connecticut with a case initiated on 1/15/2015. This case alleged physical abuse on behalf of the subject child regarding the mother. This report alleged the subject child disclosed to peers at a lunch table that it was "bad when your mom hits or kicks you on the face." The subject child allegedly reported being kicked twice in the stomach by the mother when she got upset that he was in trouble in school. The subject child stated initially that he was hit but later described being punched by his mother many times on the head. He then reported that the last time he was hit he was approximately 3, 4, or 5 years old. The family allegedly moved to Connecticut for unexplained reasons. It was reported by the DCFS worker that no marks or bruises were noted on the subject child. The progress notes indicated the subject child was a diabetic and was seen by the nurse because of a high reading that could negatively affect his behaviors. The subject child was noted to have had minor behavioral concerns at school. During an interview with the DCFS worker, the subject child disclosed that his mother would hit him regularly about his body with a belt or anything else she could find, however did not leave marks and/or bruises.

Therapy services were offered to the mother for the subject child, however she declined the services despite her knowledge of the subject child's behavior issues and challenges with adjusting to his abrupt move from New York to Connecticut. The mother explained the subject child's behavior was primarily due to his Diabetes. The report was determined to have been unfounded as they believed the subject child made allegations against the mother in retaliation, as he was upset with the move from New York to Connecticut. Support services were declined by the mother, and the case was closed on 2/20/2015.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

Additional Local District Comments

There were no additional local district comments.

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