Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-047

Prepared by: New York City Regional Office

Issue Date: Oct 14, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 04/24/2021
Initial Date OCFS Notified: 04/24/2021

Presenting Information

On 4/24/21, the sixteen-year-old female was at home with her parents when she was found in the bathroom, unresponsive. CPR was initiated and 911 was contacted. The SC was transported to the hospital where she died. The SC was found with no visible injuries; she was an otherwise healthy child.

Executive Summary

On 4/24/21, the sixteen-year-old female was at home with her parents when she was found in the bathroom, unresponsive. CPR was initiated and 911 was contacted. The SC was transported to the hospital where she died. The SC was found with no visible injuries; she was an otherwise healthy child.

The SCR registered a report on 4/24/21 regarding the death of this sixteen-year-old female, that occurred while in the home with her parents. The allegations of this report were DOA/fatality of the SC by the parents and IG of the SC by the parents and the adult sibling. ACS contacted and interviewed the hospital staff, EMS, LE, ME and parents.

ACS learned that the parents had no other minor children and the adult sibling (AS) resided in the home. It was approximately 10:00 AM, on 4/24/21, when the SM entered the bathroom and observed the SC sitting on the toilet, with her head tilted back, eyes and mouth open, and hands hanging down her sides. The SM screamed and alerted the SF and AS who responded. The SF immediately checked for a pulse and initiated CPR while the AS summoned 911 for emergency medical assistance. The SC was transported to the hospital where she was pronounced dead at 11:04 AM on the same day.

The hospital staff reported no apparent signs of maltreatment or abuse was found on the SC. The parents and AS were distraught; however, they reported the SC had an inherited medical condition and was diagnosed with another, due to the medication she was taking. EMS arrived at the home and observed the SF administering CPR to the SC who was on the floor. The ME found nothing suspicious and noted that the cause and manner of death were undetermined. LE found no criminality and made no arrest.

The ACS investigative team completed a thorough investigation. The family members reported the SC was a good and happy person despite her ailments. The neighbors reported no concerns for the family. The SC's pediatrician reported no concerns and noted the SC and parents were compliant with medication and appointments. The SC's school staff reported no excessive absences and no behavioral issues. The Specialist observed the home clean and safe with appropriate accommodations.

On 6/21/21, ACS unsubstantiated the DOA/fatality and IG allegations of the SC by the parents citing the SC's medical conditions and the ME's preliminary findings of no suspicion of criminality, abuse, or neglect to the SC.

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

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:
There were no other minor children in the home.

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: 04/24/2021 **Time of Death:** 11:04 AM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 10:14 AM
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: Using the bathroom

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	Female	16 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	Alleged Perpetrator	Male	22 Year(s)

LDSS Response

On 4/24/21, upon receipt of the SCR report, the ACS team initiated the investigation within the required timeframe. The Specialist visited the case address and interviewed the parents, adult sibling (AS), various family members, and neighbors. The SC was the only minor in the home.

The parents and AS were interviewed separately; their accounts were similar. The SM reported she awoke at approximately 10:00AM and went to the bathroom, there she discovered the SC unresponsive. She screamed and the SF and AS ran to the bathroom; the SF checked the SC for a pulse and there was none. The AS used the SF's phone to contact 911 and the operator instructed the SF to initiate CPR. EMS responded to the home shortly after and transported the SC to the hospital; they arrived at 10:40AM. The AS drove the parents to the hospital. The SC was pronounced dead at 11:04AM the same day.

The parents disclosed that SC had been receiving treatment and medication for medical conditions. The SC maintained her medication regimen and alerted them when she did not feel well; the SM dispensed the pain medication as needed. They all stated she displayed no signs of depression or suicidal ideations and she did not use drugs or alcohol. The ACS Specialist explored the SC's medication regimen to which the parents explained that when the SC was hospitalized, she was prescribed additional medications that the parents monitored. The parents reported the SC had not taken any pain medication since the ER visit.

The parents stated that on the night before the incident, the SF and PA watched a movie and ordered food to the home. The SC ate and was in her room as usual; she appeared her usual self.

The AS stated he was off work on the day before the incident, the SC felt anxious and did not want to return to in-person school, so the SF allowed her to stay home. The AS stated the SC appeared well and he asked how she was, and she said she was fine. He added that she knew she had a lot of love and support from family and that she would never contemplate suicide.

The ER Dr reported the SC appeared to have died prior to the SM's discovery. She was found with no apparent signs of abuse or neglect which was corroborated by the ME. The District Attorney's office and LE reported no criminality was found. The school staff reported the SC was mature and motivated as she prepared for college. The school accommodated the SC with schoolwork whenever she was out sick. The family declined services; they were given information for bereavement counseling in the community.

The pediatrician reported that on 4/15/21, the SC was treated in the ER for pain in her shoulder, then released. The

pediatrician and other medical specialists reported the parents were loving and caring.

On 6/21/21, ACS unsubstantiated the DOA/fatality and IG allegations of the SC by the parents citing the ME's preliminary findings that no suspicion of criminality, abuse, or neglect was found on the SC. The ME further cited the SC's medical conditions. The ME reported the cause and manner of the SC's death was undetermined. ACS also noted that the medical staff who provided treatment to the SC reportedly had no concerns for the care the parents provided and they were compliant with medications, treatment and appointments.

Official Manner and Cause of Death

Official Manner: Unknown
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?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058421 - Deceased Child, Female, 16 Yrs	058422 - Sibling, Male, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
058421 - Deceased Child, Female, 16 Yrs	058423 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
058421 - Deceased Child, Female, 16 Yrs	058424 - Father, Male, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
058421 - Deceased Child, Female, 16 Yrs	058423 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
058421 - Deceased Child, Female, 16 Yrs	058424 - Father, Male, 50 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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? No

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 was 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