Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-019

Prepared by: New York City Regional Office

Issue Date: Aug 06, 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	**Jurisdiction:** New York	**Date of Death:** 02/07/2021
Age: 17 year(s)	**Gender:** Female	**Initial Date OCFS Notified:** 02/08/2021

Presenting Information

According to the information provided via the OCFS 7065, the 17-year-old subject child came to the Pediatric Intensive Care Unit in respiratory distress and on 12/22/20 a biopsy was done. The result of the biopsy reflected a foreign substance had been injected in the child's central line. She was hospitalized on the same date and was receiving treatment. The child was reportedly diagnosed with multiple medical conditions and had undergone medical procedures. On 2/7/21 at 10:25 PM the child died.

Executive Summary

This fatality report concerns the death of the 17-year-old female child that occurred on 2/7/21. An autopsy was completed; however, the results were pending at the time of this writing. The child was the only child for the parents.

There was an open investigation with allegations of Poisoning, Noxious Substances, and Inadequate Guardianship of the child by the parents, which began on 1/5/21 and during this investigation the child, who was hospitalized, died. The Administration for Children's Services (ACS), submitted the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Services Cases. The information regarding the child's death was reported to OCFS under Chapter 485 of the Laws of 2006.

ACS received the information and investigated the circumstances surrounding the child's death. Law enforcement did not pursue a criminal investigation as the child died while hospitalized and there was no criminality suspected by the parents.

The investigation revealed that the subject child was diagnosed with a number of complex medical conditions and the parents allowed her to make decisions regarding her medication and medical care. The family had been seeking treatment for the child's condition for many years and in many states across the nation. The child was admitted into the hospital with difficulty breathing and with an unknown substance in her lungs. The child later disclosed that she administered crushed pills into her central line (a tiny tube that is placed in a vein for long-term drug therapy); however, the child was not willing to disclose what pills had been used. ACS learned from medical personnel the child was addicted to pain medication and that the medication could not be abruptly stopped. Prior to the child's death, there was a plan being made to safely lower the dosage of the pain medication while the child was in the hospital under the supervision of medical providers, and to then begin methadone treatment; however, the 17-year-old child's condition worsened and she died before the treatment could begin.

From the time the investigation began to the time of its closure, ACS interviewed family members and collateral sources. Law enforcement found no criminality regarding the death of the child, and providers noted no concerns surrounding the child's care leading up to the incident. The medical examiner explained the final autopsy report was not available as test results remained pending.

ACS found no evidence of abuse or maltreatment regarding the death of the subject child, and the investigation was unfounded and closed.

Following the death of the child, the parents who had been in New York for the child's medical treatment returned to their home out of state. The parents declined offers for bereavement counseling.

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?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Sufficient information was gathered to make determination for all allegations including those on the 1/5/21 intake report, and the determination made by the district to unfound the report was appropriate. However, there were no allegations pertaining to the death of the child.

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 level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion was commensurate with the 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: 02/07/2021 **Time of Death:** 10:25 PM

County where fatality incident occurred:	New York
Was 911 or local emergency number called?	No
Did EMS respond to the scene?	No
At time of incident leading to death, had child used alcohol or drugs?	Unknown

Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant

☐ Playing ☐ Eating ☐ Unknown
☒ Other: Hospitalized

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	17 Year(s)
Deceased Child's Household	Father	No Role	Male	62 Year(s)
Deceased Child's Household	Mother	No Role	Female	56 Year(s)

LDSS Response

On 2/8/21, ACS received information regarding the death of the child. ACS initiated their investigation of the cause and circumstances of the child's death within 24 hours and coordinated their efforts with their MDT. ACS learned there were no SS or other CHN that resided in the household, and the family had no CPS history in New York State. The child died during the open investigation which began on 1/5/21.

On 2/8/21, ACS contacted medical personnel and learned the child was initially seen in January 2018 and treated for pains and bruises due to a preexisting medical condition. Child was hospitalized on 12/22/20 and remained hospitalized until her death on 2/7/21.

On 2/8/21, ACS contacted the father to discuss bereavement services. The father said he and his wife would seek bereavement counseling privately. The parents have denied intentionally giving the child anything that would harm her or administering any other type of medical treatment to harm the child.

The case documentation reflected extensive medical information regarding the child's treatment over the years. Additionally, the case documentation reflected the child admitted to inserting the medication into her central line. The child refused to identify the medication.

From an out of state medical Child Abuse Specialist who had contact with the child, ACS learned the child had been healthy and high functioning up until she reached 7 years old. The symptoms of the child's conditions manifested and the parents sought medical assistance in various states. The Specialist indicated many physicians were concerned about medical child abuse.

On 2/11/21, ACS summarized findings from medical providers. According to the case notes, the child had been administering her own treatment's medication prior to being admitted into the hospital. Medical providers the child had an extensive knowledge of her medical conditions "often sounding like a doctor." The child was reported to have been a

strong advocate for herself and her medical care. The medical staff noted that the child was on a high and frequent dosage of opiates and plans were being made for the child to begin methadone treatment. Between 2/4/21 and 2/7/21, the child's condition worsened and she died. The Specialist said the parents were overconcerned about the child.

On 2/24/21, the Medical Examiner indicated that the autopsy report was still pending as extensive laboratory work was required.

The case documentation reflected the Specialist made a number of attempts to contact the detectives assigned to investigate the possible criminal elements of the case and sought legal consult regarding the family. ACS later learned no charges would be filed pending the final autopsy result. ACS Family Court Legal Services determined there was no basis to file a petition as the parents only child had died.

On 3/7/21, ACS unsubstantiated the allegations stemming from the 1/5/21 report on the basis of no credible evidence. There were no allegations pertaining to the death of the child.

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 reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Team in the NYC region.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
There were no surviving siblings or other children in the household; the only child died.

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	☐	☐	☐	☐	☐	☒	☐

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.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? N/A
Explain:
The parents refused services and returned to their home out of state.

History Prior to the Fatality

Child Information

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/05/2021	Deceased Child, Female, 17 Years	Mother, Female, 56 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 17 Years	Mother, Female, 56 Years	Poisoning / Noxious Substances	Unsubstantiated	
	Deceased Child, Female, 17 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 17 Years	Father, Male, 62 Years	Poisoning / Noxious Substances	Unsubstantiated	

Report Summary:
On 01/05/21, the SCR registered a report with concerns that the mother and father injected and unknown substance in the 17-year-old child's intravenous (IV) tube. As a result, the child was experiencing acute respiratory failure. The report alleged the child was in need of protection in New York State.

Report Determination: Unfounded **Date of Determination:** 03/08/2021

Basis for Determination:
The allegations of Poisoning, Noxious Substance and Inadequate Guardianship of the 17-year-old child by the parents were unsubstantiated on the basis of no credible evidence. The child admitted to inserting pills into her central line which exacerbated her condition.

OCFS Review Results:
ACS initiated the investigation in a timely manner and made diligent efforts to contact medical providers in New York State and elsewhere. ACS obtained and reviewed lengthy medical records regarding the child's condition. ACS staff sought the assistance of medical consultants during the investigation and there was evidence of supervisory consultation and involvement. Case activities were commensurate with case circumstances. The determination was appropriate. ACS obtained sufficient information to determine the allegations of the report and appropriately unfounded the report.

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

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

The family had CPS history in another state; however, the details were unknown in spite of ACS's attempt to obtain the information.

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