Child Fatality Report

Report Identification Number: SY-19-012

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

Issue Date: Aug 09, 2019

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		

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Broome
Gender: Male
Date of Death: 02/15/2019
Initial Date OCFS Notified: 02/15/2019

Presenting Information

An SCR report was received with concerns the 17-year-old subject child was severely asthmatic, and despite knowing this, the grandmother would smoke in the child's presence. As a result, the child had an asthma attack and died on the night of 2/14/19.

Executive Summary

This fatality report concerns the death of a 17-year-old male subject child that occurred on 2/15/19. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's maternal grandmother (MGM). Broome County Department of Social Services (BCDSS) received the report and investigated the child's death. The final autopsy report listed the cause of death as "Chronic obstructive pulmonary disease (asthma)," and the manner of death as natural.

At the time of the child's death, he resided with his grandmother, grandfather (MGF), and maternal uncle (MU). The grandmother had joint custody of the child along with his mother; however, the child chose to reside with the grandparents. The investigation revealed on the night of 2/14/19, the child was in his bedroom playing video games, and the grandmother had gone to bed around 10:15 PM; the grandfather was in a different room in the house and the uncle was at work. At approximately 11:30 PM, the child yelled from his room that he could not breathe. The grandparents found the child in distress on his bed and called emergency services. First responders arrived at the home shortly thereafter, and transported the child to the hospital. The child was pronounced deceased at 12:25 AM on 2/15/19.

It was discovered the child had been living with asthma since he was three years old, and was prescribed two inhalers and a Nebulizer to be used as needed. The evening prior to his death, the mother had dropped off refills of his inhalers. Family members reported the child did not appear at all symptomatic throughout the day and hours leading up to his death, and the child and family members knew how to manage the asthma.

From the time the investigation began to the time of its closure, BCDSS met with and interviewed family members as well as several collateral sources. Appropriate services were offered in response to the child's death and there were no criminal charges brought against the caregivers by law enforcement. It was determined the grandparents acted promptly and appropriately upon learning the child was in distress, and BCDSS found no evidence to indicate the grandmother's actions or inactions led to the child's death. The report was unfounded and closed.

PIP Requirement
BCDSS will submit a Program Improvement Plan (PIP) to their Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) BCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, BCDSS will review the plan(s) and revise as needed to further address on-going 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?** 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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
BCDSS gathered sufficient information to complete the final safety assessment. There was no information gathered surrounding how SC maintained his asthma treatment from October 2017 to February 2019, as his pediatrician reported he had not been seen during that time.

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:
There was insufficient information gathered surrounding how SC maintained his asthma treatment from October 2017 to February 2019.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	BCDSS learned from SC's pediatrician that SC had not been seen since 2017. The record did not reflect if caregivers were asked how SC's asthma was monitored and how prescriptions were refilled during that lapse in time.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 02/15/2019 **Time of Death:** 12:25 AM

Date of fatal incident, if different than date of death: 02/14/2019
Time of fatal incident, if different than time of death: 11:30 PM

County where fatality incident occurred: Broome
Was 911 or local emergency number called? Yes
Time of Call: 11:30 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: Playing video games.

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 40 Minutes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	Aunt/Uncle	No Role	Male	28 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	55 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	58 Year(s)
Other Household 1	Mother	No Role	Female	36 Year(s)
Other Household 1	Sibling	No Role	Male	14 Year(s)
Other Household 1	Sibling	No Role	Male	11 Month(s)
Other Household 1	Sibling	No Role	Female	1 Year(s)
Other Household 1	Sibling	No Role	Female	19 Year(s)
Other Household 1	Sibling	No Role	Male	11 Month(s)
Other Household 2	Father	No Role	Male	40 Year(s)
Other Household 3	Other Adult - BF of SS	No Role	Male	37 Year(s)

LDSS Response

On 2/15/19, BCDSS received the SCR report regarding the death of SC, which occurred on that same date. BCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. BCDSS learned SC resided with his maternal grandparents and uncle, and no other children lived in that household.

On the date the report was received, BCDSS and law enforcement met with the grandparents, uncle, and SC's mother in their respective homes. Both homes were observed to be appropriate with no safety concerns noted. BCDSS was informed SC had been living with his grandparents and uncle for approximately five years. This was a family decision based on SC's preference, and did not involve Family Court or BCDSS. SC remained in regular contact with his mother and 5 siblings, all of whom resided with his mother. During interviews, BCDSS was informed SC had suffered from asthma since the age of 3; BCDSS observed SC's inhalers and nebulizer. The family reported SC's asthma was under control and he saw his pediatrician regularly. It was revealed the uncle was at work at the time the fatal incident occurred; however, the grandmother and grandfather were at home. The family reported SC had been acting normally all day and showed no signs of asthmatic symptoms or distress. The mother explained she had spent time with SC throughout the day on 2/14/19, and in the evening, she went to pick up his inhaler refills at the pharmacy. At 7:15 PM, she dropped off the refills. The mother stated SC appeared fine when she interacted with at that time. The mother left the home prior to the fatal incident, and the grandmother stated she arrived home from work that day around 5:00 PM. The grandparents explained at around 10:15 PM on 2/14/19, the grandmother went to bed and walked by SC's room to find him playing on his tablet; the grandfather was in another room in the house. The grandparents stated approximately 40 minutes later they heard SC say that he could not breathe. Both grandparents went into SC's room to find SC with labored breathing, and the grandmother called 911. The grandfather stated the grandmother administered CPR until emergency services arrived and transported SC to the hospital. The family denied SC was taking any other medications and reported he was otherwise healthy.

BCDSS spoke with SC's medical providers and learned SC was last seen for a physical exam in October 2017; there were no concerns noted. According to documentation obtained, the pediatrician's office made several attempts to reach the mother after she had canceled SC's appointment in February 2018. A nurse at the practice reported the mother finally got in touch with the pediatric office in February 2019, and SC's inhaler refills were called into the pharmacy; SC's physical appointment was scheduled for 2/27/19. SC was not prescribed a rescue inhaler. The record did not reflect how SC's asthma was treated and maintained during the time he went unseen by his pediatrician, nor how this lapse in care may have impacted his condition.

On 3/7/19, BCDSS assessed the safety of SC's surviving siblings and interviewed those who were verbal. None of the siblings were present the day of SC's death, and therefore had no information surrounding what occurred.

BCDSS spoke with many collateral sources throughout the case and offered family members appropriate services in response to the fatality. Law enforcement found no criminality regarding the death of SC. BCDSS found no evidence to support the allegations in the report; therefore, the case was unfounded and closed.

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: This fatality investigation was conducted by the Broome County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Broome County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050803 - Deceased Child, Male, 17 Yrs	050804 - Grandparent, Female, 55 Year(s)	DOA / Fatality	Unsubstantiated
050803 - Deceased Child, Male, 17 Yrs	050804 - Grandparent, Female, 55 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:
BCDSS spoke with all appropriate collateral sources. The biological fathers of SC and the SS were interviewed via phone.

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 safety and risk assessments throughout the case were completed timely and adequately. Appropriate services were offered to the family regarding the death of the SC.				

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: No surviving children were removed as a result of this 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
BCDSS offered appropriate services in response to SC's death. BCDSS also made a general offer of any services that may be needed to all caregivers, which was declined.

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:
BCDSS provided the caregivers referrals for bereavement services for the surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BCDSS provided the caregivers and biological father referral for bereavement services. BCDSS also gave the family information regarding funeral expense assistance.

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?	No
Was the child acutely ill during the two weeks before death?	No

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)
09/22/2016	Sibling, Female, 16 Years	Mother, Female, 33 Years	Educational Neglect	Unsubstantiated	No
	Sibling, Male, 12 Years	Mother, Female, 33 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 16 Years	Grandparent, Female, 52 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 12 Years	Grandparent, Female, 52 Years	Educational Neglect	Unsubstantiated	

Report Summary:
This report was received with concerns MGM and BM failed to register the children in school and were at risk of academic regression. The report alleged the school tried several times to reach the family, but were unsuccessful.

Report Determination: Unfounded | **Date of Determination:** 12/05/2016

Basis for Determination:
BCDSS interviewed all household members and collateral sources. It was discovered the family had recently moved and had to change school districts. BCDSS assisted the family with this, and offered additional appropriate services which were denied. The case was unfounded and closed.

OCFS Review Results:
This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/17/2016	Sibling, Female, 16 Years	Other Adult - BM's boyfriend, Male, 34 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Sibling, Female, 16 Years	Other Adult - BM's boyfriend, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This report was received with concerns regarding the then 16yo. The report alleged the SM's boyfriend was aggressive toward the CH, and would grab and push her. Further, the report stated on the morning of 3/17/16, the BM's boyfriend grabbed the CH and threw her against a wall as a form of punishment. As a result, the CH sustained redness to her side.

Report Determination: Unfounded | **Date of Determination:** 07/29/2016

Basis for Determination:
BCDSS completed home visits and interviews. All CHN were assessed, and the allegations were discussed. BCDSS discovered the CH had a history of mental health concerns and BCDSS assisted BM with referrals for further counseling services. BCDSS found no credible evidence to support the allegations and unfounded the case. The family was referred to community-based services.

OCFS Review Results:
This investigation met all statutory requirements.

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

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

10/2014: UNF for EdN and IG against BM and BF regarding SC and SS.
9/2014: UNF for IG and L/B/W against BM and BF regarding SS.
11/2009: UNF for XCP and IG against MGM and MGD regarding SC and two SS.
9/2000: IND for IG against BM and BF regarding SS.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

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

BCDSS agrees with OCFS' findings, that BCDSS' initial and final safety assessments were based on sufficient information and were appropriate.

Apart from BCDSS' actual appropriate investigation safety findings, for reasons detailed below, BCDSS disagrees documentation did not reflect if caregivers were asked how SC's asthma was monitored and how prescriptions were refilled.

On 2/15/19 (date of death) BCDSS interviewed grandparents, uncle and mother. They provided SC's inhalers and medications. BCDSS documented mother dropped off new inhaler for SC. When examined by BCDSS and police, 200 puff inhaler had 194 puffs remaining. Photographs of inhaler were taken. Those photos are part of BCDSS' documented investigation file.

Further, grandmother and mother both reported SC was always in possession of his medications. BCDSS documented mother reported she recently switched pharmacies, due to switching doctors. BCDSS documented mother scheduled SC doctor's appointment for 2/27/2019.

BCDSS documented SC was seen 10/17/2017 by his doctor. BCDSS documented SC was described as generally in good health, with "no signs… of respiratory distress." Doctor's records and nurse's verbal report, documented by BCDSS, substantiated SC was always in possession of inhalers, including: Ventolin, Q Var, and a nebulizer. BCDSS documented mother's statement that should SC ever run out of medication, she was prescribed same medication and provided it for SC.

Contrary to OCFS' finding, throughout BCDSS' investigation mother, grandparents and medical providers were asked

about SC's medical condition and prescriptions. Documented answers and photographic evidence within the case record were logical and substantiated BCDSS' appropriate initial and final safety assessments.

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