NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-072 **Prepared by: New York City Regional Office**

Issue Date: 12/27/2016

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: 24 day(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 07/08/2016
Initial Date OCFS Notified: 07/08/2016

Presenting Information

The 7/8/16 SCR report alleged on 7/8/16, the mother was burping the 24-day-old infant after bottle feeding her. The infant spat up blood. The mother called the father who was running an errand. The father went to speak with a pediatrician, across the street from the home, about the situation. The father returned home from the pediatrician and found the infant in the crib, blue and unresponsive. The report alleged mother failed to monitor the infant's health by leaving her unattended in the crib after there was an obvious health concern. The infant was transported to the hospital after 911 was called. The infant arrived at the hospital at 1:52 PM and was pronounced dead at 2:24 PM. There was no plausible explanation for the infant's death at this time.

Executive Summary

The 24-day-old female infant (SC) died on 7/8/16. An autopsy was not authorized by the family due to religious beliefs. The ME conducted an external examination and x-rays were taken. The ME listed the cause and manner of death as undetermined.

The allegations of the 7/8/16 report were DOA/Fatality and IG of the infant by the parents.

ACS learned that according to the SM, she fed the SC at about 12:45 PM and while burping her SM saw that her shoulder was wet. The SM saw that there was blood in the vomit. The SM was on the phone with the SF at the time; she told him of her observation and asked the SF to stop at the Dr.'s office which was close by . The SF spoke with the Dr. who stated the child may have a dry nose or may have a scratch on the face, mouth, or "something". The SM said the child did not have any scratches, neither was there anything abnormal noted. The SM said she placed the child on the bed and tended to the other children until the SF returned home.

The SF confirmed the mother's statements and added that the doctor told him to administer a dose of saline to the nose as the child may have a "dry nose". The SF said he told the Dr. that the SC had been at the Dr.'s office on 7/5/16 for the same complaint. The SC was treated, observed, and released to the parents with no scheduled follow-up appointments. The SF said when he arrived home and entered the bedroom, the SC was lying face up on the bed. He reported he went over to the SC who was not crying or moving, but seemed discolored. He said he touched the SC's hand which felt cold and when he began to lift the SC from the back of the head he saw blood coming from the child's nose. The SF said he called 911.

On 7/14/16, a conference occurred. The parents agreed to PPRS. Later, the family declined PPRS as they felt that it was no longer needed.

The 24-hour safety assessment was not completed until 7/10/16 and was not adequate as it focused on the deceased child and not on the 1-year-old and 2-year-old surviving children.

On 9/2/16, ACS unsubstantiated the allegations of DOA/Fatality and IG of the infant by the parents. ACS based their

decision on the ME's findings which reflected an undetermined cause and manner of death. ACS documented based on the SC's multiple medical issues and ME's findings, the actions and behavior of the parents did not contribute to the SC's death. Prior, to the SC's death, the parents had reported to medical staff concerns regarding the SC. The parents sought medical care for the SC and each time they took her for medical care, they were informed that she was well, and sent back home. ACS further added the parents made sure the child had all required routine and emergency medical care. The parents provided the SC with a minimum degree of care.

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?** 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:
NA

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour safety assessment was not completed until 7/10/16 and was not adequate as it focused on the deceased child not on the 1-year-old and 2-year-old children.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/08/2016 **Time of Death:** 02:24 PM

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

County where fatality incident occurred: QUEENS
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? N/A
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: lying on the bed

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not 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	Female	24 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

LDSS Response

On 7/8/16, LE reported that the SM said the SC was crying, she picked up the SC and rubbed, and patted her back. SM felt

moisture on her left shoulder. She thought the SC spat up, but she saw it was blood in the nasal passage. SM contacted the SF who was not home. He went to the Dr. who was close by to explain what occurred. The Dr. felt that it was a possibility of dry skin and advised the SF to get nasal spray. The SF went to the pharmacy and went home 10 minutes later. The SM was bathing one of the children in the sink; the SF picked up the SC who was blue. Later, LE informed ACS that no wrong doing on the part of the parents was found.

On 7/12/16, the attending Dr. reported the SC was pale, and had no respiration or pulse. CPR and resuscitation was performed on the SC for 30 minutes but there was no change. The parents were cooperative and she found them to have acted appropriately. The Dr. said the SF sought medical help for the SC three days earlier by taking her to the emergency room (ER) of a hospital as she was sick. The parents reported the SC had blood in the stools and vomiting. The SF was concerned for the SC had been crying for 5 days and he felt something was wrong. The SC was observed in the ER for 3 to 4 hours but nothing was found. She was discharged and the parents were instructed to have the SC seen by her Dr.

On 7/12/16, the SF reported that he did not know the time he left the home, but it was 12:30 when he left his place of worship and went to the pharmacy. At the pharmacy he spoke with the SM. Sometime after speaking with her, she phoned and told him the SC had vomited. He was close to the family's Dr. and walked to the Dr.'s office. He spoke with the Dr. who said that what he was describing presented to be normal. He was instructed to wait and observe the SC; if the SC's condition did not improve, he should bring the SC in the following day. The SF returned home and when he arrived, he saw the dark blood on the SM's shoulder.

The SM reported that on 7/8/16, the SC was crying. She said the SC did not sleep the night before. The SF stopped by the pharmacy to pick up a prescription but called her as there was a problem with the children's medical insurance. While speaking to him, she told him of the SC's condition. They agreed that the SF would stop by the family Dr.'s office to obtain medical advice. The SM said she did not think of calling 911 as the SC had been taken to the hospital several days earlier and was told she was fine. She also spoke with the Dr. the previous day and the Dr. explained that what she was described sounded normal. The SM said at one point, the SC seemed to be dozing off so she placed the SC on top of the bed, on her back. The SM said the SC seemed calm; therefore, she (the SM) she went to tend to the two other children.

On 8/1/16, the Dr. confirmed that he saw the SF on 7/8/16 and the SF told him the SC vomited twice that day. The Dr. said he told him that if the SC's condition did not improve, to bring her in that day and to continue to give her Pedialyte. The doctor said he could clearly recall the SF stating that the SC's condition had improved and that the SF may have mentioned of a tiny amount of blood coming from the SC's nose. He did not recall the SF stating anything about the SC's mouth or that the SF was informed that the SC's bleeding from the mouth could have been due to having dry lips.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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)?No
Comments: The investigation adhered to previously approved protocols for joint investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
032321 - Deceased Child, Female, 24 Days	032322 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
032321 - Deceased Child, Female, 24 Days	032322 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
032321 - Deceased Child, Female, 24 Days	032323 - Father, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated
032321 - Deceased Child, Female, 24 Days	032323 - Father, Male, 34 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The one and two year old could not hold a conversation to provide details regarding the SC's death; however, they were observed and assessed as safe.

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 safety 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?	☐	☐	☒	☐

Explain:
The 24-hour safety assessment was focused on the deceased child not on the 1-year-old and 2-year-old children.

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	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Documentation reflected ACS provided a crib for the 1-year-old child and a toddler bed for the 2-year-old child. The

family declined PPRS. On 7/26/16, the family was seen at the CAC. The 1-year-old and 2-year-old children were seen by a Dr. for a comprehensive forensic evaluation. The Dr. said that she did not observe any signs that the children were mistreated.

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:
A comprehensive forensic evaluation was performed by the CAC.

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 PPRS which initially they accepted the service; however, at a later time they declined it.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
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?	No
Was the child acutely ill during the two weeks before death?	Yes

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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

The parents and children were not known to the SCR or ACS.

Known CPS History Outside of NYS

There was no known history outside of NYS.

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

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