NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-077 **Prepared by: New York City Regional Office**

Issue Date: 2/3/2017

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

Presenting Information

The 7/24/16 report alleged on 7/24/16, the SF was caring for the 17-month-old child. It was unknown if the BM, grandmother, or 3-year-old child were home at the time. The SF gave the SC some milk and laid her down for a nap in her bed at approximately 1:00 PM. The SF checked the SC at 3:00 PM and put some skin cream on her. SF observed her to be asleep, yet moving around. At 3:30 PM, the SF went to the SC to change her diaper. The SC was faced down on the bed, pale and unresponsive. SF placed her in his car and drove her to a nearby hospital. Upon arrival at the hospital, the SC had no heartbeat and was cyanotic, but she had no visible injuries. All attempts to resuscitate the SC failed and she died on 7/24/16. The SC had a history of a medical condition, but it was unknown if this contributed to her death. As the SF was the only care provider to the SC at the time of her death, he was being made an alleged subject.

Executive Summary

The 1-year-old female child (SC) died on 7/24/16. NYCRO received the autopsy report on 1/10/17. The ME listed the cause of death as undetermined and the manner as natural.

The allegations of the 7/24/16 report were DOA/Fatality and IG of the 1-year-old child by the SF.

The SC had a pre-existing medical condition. The parents left the home around 9:00 AM to take the 3-year-old child to a Dr.'s appointment. After the Dr.'s appointment, the BM went to work. The PGM went out to visit a friend. The SF was home alone with both children. The SF observed the SC asleep on her back in his full size-bed. The SC was positioned in the middle of the bed. At the foot of the bed was a body pillow and blanket. The SC was lying down with a pillow under her head and a bottle of milk in her mouth; SF removed the bottle. An hour later, at about 2:00 PM, the SF checked the SC who was still sleeping. SF said the SC seemed fine. At about 3:00 PM, he again checked the SC and she was still asleep. The SF applied lotion to the SC's legs, arms and back of the neck. The SF said about 30 minutes later he checked the SC who was still asleep. He found she needed a diaper change. The SF began to change the SC's diaper and observed she was face down. He turned the SC around and observed that her color seemed unusual.

The SF transported the SC and 3-year-old child by car to the hospital. He placed the 3-year-old child in her car seat, and placed the SC face up behind the driver's seat. The SC's car seat was not in the car as they did not plan on using it that day. The SF drove to the hospital which was about a six-minute drive from the case address. He reported there was no traffic on the way to the hospital. The SF did not call 911 as he reckoned he could get the SC to the hospital before medical assistance would arrive at the home.

The BM said she was not home at the time of the incident. The BM was at work when she received a call from the SF informing her of what occurred. The PGM reported that at 1:30 PM, the SF arrived home. The PGM said she was not in the home when the child passed away. She said the SF called her at about 3:40 PM and told her something was wrong with the SC.

On 7/27/16, a child safety conference (CSC) occurred. No court intervention was initiated as there was no indication that the parents have acted in a way to cause the SC's death or place the 3-year-old child in danger of serious harm.

On 7/28/16, the ME reported there was no sign of trauma on the SC. The ME said suspected the SC had history of illness. The ME's preliminary tests showed negative results. Several additional tests were conducted which would take several months for the results.

On 8/24/16, LE informed ACS that there was no criminality and the investigation was closed. LE was awaiting the ME's results.

On 9/6/16, ACS referred the family for PPRS.

The 24-Hour safety assessment was not completed in a timely manner as it was not completed until 7/26/16. The 9/26/16 safety assessment was inadequate as ACS stated a safety factor existed. ACS did not include justification to support the selected safety factor. Also, in the safety factor, ACS noted the 3-year-old child's needs were being met.

On 9/27/16, ACS Unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SF. ACS based the determination on the ME's preliminary findings and the lack of a conclusive determination as to the cause of death. ACS noted there was no evidence indicating that the parents played a role in the child's death. The parents took the necessary steps and they obtained medical treatment for the SC as needed. The parents followed up with medical recommendations as far as following up with the child's Dr. although the SC did not have a diagnosed medical conditions.

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

Explain:
N/A

Was the decision to close the case appropriate? N/A

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:	For the 7/24/16 report, ACS completed the 24-hour assessment on 7/26/16.
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.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The 9/26/16 safety assessment was inadequate as a safety factor was selected despite the associated comment reflected the 3-year-old child's needs were being met.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
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.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	The documentation reflected that when the parents were interviewed on 7/25/16, the SF and BM said each of them had been giving the SC a bath when the SC was ill in April 2016. ACS did not adequately address SC's head injury with the family.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
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: 07/24/2016 **Time of Death:**

Time of fatal incident, if different than time of death: 03:30 PM

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	59 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

ACS staff interviewed the hospital social worker (SW) on 7/24/16. The SW said upon arrival at the hospital, the SC had no heart beat and was cyanotic (blue). The SW said as per hospital records, the SC was seen in the hospital Emergency Department for a medical condition on 4/28/16 and 5/18/16. During the 4/28/16 visit, the SC was admitted. For the 5/18/16 visit, the SC was examined and released. The records noted the SC had a head injury after having been given a bath by the BM. Both times, the SC needed follow-up with the family Dr.

On 7/24/16, the SF said the children were left in the care of the PGM as he and the BM left the home at 9:00 AM. He said he returned home at about 2:00 PM. When he returned home, the SC was lying on her back drinking milk from a bottle the PGM had given her. At about 3:00 PM, he observed the SC was asleep. He removed the bottle from the SC and placed cream on her body and laid the SC on her stomach with her head slightly turned. Sometime between 3:00 PM and 3:45 PM, the SF applied cream on the SC's skin. The SC's skin complexion caused him concern. While obtaining information

from the SF, the SF was being rushed by LE as he was to be further interviewed.

On 7/25/16, the SF was again interviewed. The SF said the parents left the home around 9:00 AM to take the 3-year-old SS to a medical appointment. The SF informed ACS that in April 2016, the SC had stopped breathing. He said he was giving the SC a bath in the kitchen and observed the SC's eyes turned white. The parents took the SC to the hospital. The second episode of illness occurred when the parents were driving from Brooklyn after visiting the MGM. The SC became ill and they were told they could put ice on her head to cool her and reduce her temperature. They transported her to the hospital.

The SF said the SC spent a week in the hospital and received medical treatment. Following the two ER visits, the parents took the SC to the family Dr. as directed. The SF said the physicians did not have concerns. The SF denied the SC had "head injuries." He said the two children were playing and the SC bumped her head on the rail of the crib. The SF said this bump was observed when the SC had stopped breathing during one of the visits to the hospital.

The BM said the SC received examinations in the hospital in April and May, 2016 due to a medical condition. In April 2016, the SC had an abnormal body temperature and the BM gave the SC a bath and took her to the ER. The parents followed up with the family Dr. who did not inform them of any medical concerns. Regarding the May 2016 episode of illness, the parents had been traveling home from visiting relatives when they observed the SC was very quiet, stared, and was unresponsive. When they got home, the BM put the SC in the crib and went to give the 3-year-old a bath. The SF was parking the car. Several times the BM checked the SC while the 3-year-old was in the tub. When the SF came in, they picked up the SC and observed her body was shaking. They took the SC to the hospital. The BM said they were not provided instructions on how to respond to the SC's symptoms of illness. BM said the Dr. told them to place ice on the SC's head to help decrease body temperature, and the parents complied as instructed. The Dr. told them the SC exhibited symptoms of due to illness.

ACS found there were two physicians who had examined the children. The Dr. 1 had examined the SC in 2015. Later, Dr.2 informed ACS that he was not aware of any hospitalizations for either child within the 12-month period preceding July 2016. The SC was last seen on 6/2/16 for a well-check visit and had an office visit on 5/19/16.

On 8/3/16, the Specialist discussed the case with the Medical Consultant (MC). After reading a letter from Dr.2, the parents may not have told the Dr. about the symptoms of illness. The MC said more information needed to be obtained from Dr.2. The Specialist contacted the Dr.2's office but he was unavailable.

Official Manner and Cause of Death

Official Manner: Natural
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
033881 - Deceased Child, Female, 1 Yrs	033883 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
033881 - Deceased Child, Female, 1 Yrs	033883 - Father, Male, 35 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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 SF did not contact 911 at the time of the incident. The 3-year-old SS was unable to effectively communicate.

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?	☐	☐	☒	☐

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?	☐	☒	☐	☐
Explain as necessary:				

N/A

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:
The family received PPRS. ACS attempted to locate a play therapist in Queens, but none was located.

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:
The SS received case management services and casework counseling services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family accepted PPRS.

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?	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

The family was 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