Child Fatality Report

Report Identification Number: NY-16-096

Prepared by: New York City Regional Office

Issue Date: Mar 21, 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 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 09/05/2016
Initial Date OCFS Notified: 09/05/2016

Presenting Information

The 9/5/16 SCR report alleged, on 9/4/16 the PA checked the 1-month-old SC in his bedroom and found him unresponsive with blue lips. The PA drove the SC to a nearby hospital where they were able to resuscitate him. The SC was subsequently transferred to another hospital. The morning of 9/5/16 at 10:38 AM, the SC passed away. The SC was otherwise healthy and there was no plausible explanation for his death. The parents had no roles.

Executive Summary

This one-month old male infant died on 9/5/16. According to the ME, the autopsy results are pending further studies. As of 2/22/17, NYCRO has not received the autopsy report.

The allegations of the 9/5/16 report were DOA/Fatality and IG of the SC by the PA.

On 9/5/16, the ACS Specialist interviewed the PA regarding the events that led up to the incident. The SC had no signs or symptoms of illness prior to the incident. According to the PA, the SC shared a queen sized bed with the parents and SS. There was no crib for the SC. The PA said she fed the SC at approximately 5:00 PM on 9/4/16. The SC was fed 3oz bottle of formula, and then burped and bathed. The PA placed the SC to sleep on the queen sized bed in the room of the BM as usual; there was no crib. The PA explained the SC shared the bed with the BM to comfort the SC when he awakened in the night. Around 7:00 PM, the PA prepared the SC's formula and went to the bedroom. The PA observed the SC lying face up with the arms up with palms facing upward on the bed with his eyes open. The PA picked up the SC who appeared to be have faint breathes and was heard moaning as though he was in discomfort. The PA observed the SC was an unnatural white in color, his hands felt cold and his lips appeared purple. The PA contacted the BM, followed her instructions and took the SC to the ER.

The PA stated she thought calling 911 would delay the process as there was more of a chance with the PA driving there herself along with great paternal aunt (GPA). The PA, GPA and SC arrived in the hospital ER. The PA and GPA witnessed the staff perform emergency duties. At approximately 8:00 PM, the medical staff informed the PA and GPA that the SC was ill and required transport to a more equipped hospital. The PA stated she and the SC were transported and arrived at the Cornell Hospital around 9:00 PM. The PA called the BF; who provided medical consent for the SC to receive a medical procedure. The SC remained hospitalized and his condition worsened. The SC died on 9/5/16 at 10:38 AM.

On 9/6/16, the Specialist interviewed the parents separately in the home. The SC resided in the home with the parents, SS, PA, PU and an adult male cousin. The parents, SS, PU and cousin were not home at the time of the incident; the BF, PU and the cousin work out of state and the BM was out of the country with the SS on a planned visit to the PGM. The BM stated the visit was scheduled for 24 days; where she planned to leave the SS with the PGM for two months and eventually reunite with the BF out of state.

ACS opened the Family Services Stage of the case on 9/14/16. ACS offered the family Early Intervention (EI) referral. The family declined bereavement services. The initial Family Assessment Service Plan (FASP) was due on 10/15/16. ACS approved the FASP on 11/4/16, and did not provide an explanation for the late approval. During the

investigation, the PA gave birth and ACS made sufficient home visits (HV) and appropriately completed safety assessments of the SS and newborn cousin. ACS observed a crib for the cousin and ensured the newborn attended a wellness visit. The BM and SS left the country with an undetermined date of return. There were no safety concerns.

On 11/4/16, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the PA. ACS found no credible evidence to suggest that the PA inflicted any injuries or intentionally caused the SC's death.

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? 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:
ACS gathered sufficient information to make determination for all allegations.

Required Actions Related to the Fatality

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

Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was due on 10/15/16. ACS approved the FASP on 11/4/16.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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: 09/05/2016 **Time of Death:** 10:38 AM

Date of fatal incident, if different than date of death: 09/04/2016
Time of fatal incident, if different than time of death: Unknown

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
How long before incident was the child last seen by caretaker? 2 Hours
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	Aunt/Uncle	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	No Role	Male	25 Year(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)

LDSS Response

On 9/5/16, LE stated the SC was initially taken by the PA to Queens Hospital on 9/4/16. The SC was transported Cornell

Medical Center where the SC remained until he died on 9/5/16. Prior to 9/4/16, the SC was left in the care of the PA for 8 days. The BM went out of the country with the SS to visit the MGM. The BM planned to leave the SS in the care of the MGM and return to NY. LE observed the home was clean, orderly and neat with plenty of necessities for the SC. The BM's bedroom where the SC died was declared a crime scene. No arrests were made.

According to the Queens Hospital staff, the SC was born healthy with no medical complications. On 9/4/16, the SC arrived at the hospital at 7:21 PM in cardiac arrest with no visible or suspicious injuries. The staff performed CPR and administered emergency medication. The SC's condition was fragile; he was placed on a machine and transferred to Cornell Hospital.

The Cornell Hospital staff stated the SC was admitted with no marks, bruises or visible trauma. The SC was given emergency medication and exploratory procedure was conducted to determine the cause of the SC's condition.

On 9/6/16, the Specialist visited the home to assess the SS for safety. The Specialist observed the SS was free of bruises and marks. ACS observed plenty of provisions for the SC in the home. ACS observed the three-bedroom apartment did not have window guards nor a working smoke/CO2 detector.

The Specialist interviewed the parents separately in the home. The BM said she communicated with the PA daily; 4 or 5 times per day while she was away. The PA notified the parents of the SC's condition. The BF stated he consented for the hospital to perform an emergency procedure on the SC. The BF returned to NY on 9/5/16, at approximately 8:20 AM, and he arrived at the hospital before the SC died. On 9/6/16, the BM, SS and PGM returned to the NY after the SC died. The BM stated she received safe sleep education. ACS observed relatives were in the home to provide support to the family. There were no discrepancies between the statements made by the family.

On 9/7/16, the ME stated the autopsy results are pending further studies. There were no signs of trauma nor signs of abuse/maltreatment observed on the SC.

On 9/8/16, the Dr. stated there were no concerns regarding the care the SC and SS received by the parents. The SC's family recently brought the SC to the office for digestive concerns. The Dr. recommended a change in the SC's formula. After the formula was changed, the SC gained weight. The SC's and SS's immunizations were up to date. There were no indication of abuse/maltreatment of the children.

On 9/15/16, ACS held a family team conference (FTC). The parents and the PA participated. The PU attended as a support for the PA. The Specialist discussed the identified safety concerns and a safety plan for the SS was developed. The parents were directed to install window guards in the home, obtain a working smoke/carbon monoxide detector and be the sole caretakers for the SS.

The Specialist conducted a HV and counseled the PA and PU on safe sleep precautions; as the PA was pregnant. ACS observed the identified safety concerns were remedied and the SS had her own bed.

On 9/30/16, the Specialist interviewed the GPA who stated on 9/4/16 she was in the apartment at 4:00 PM. The PA took a shower and went back into the bedroom and discovered the SC's face was dark. The PA and GPA took the SC to the hospital. The PA called the parents . The GPA stated she helped the family with shopping, laundry and cleaning and she had no child care responsibilities.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
031046 - Deceased Child, Male, 1 Mons	031050 - Aunt/Uncle, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
031046 - Deceased Child, Male, 1 Mons	031050 - Aunt/Uncle, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
There were no "other persons named" in the report.

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 refused ACS offer for preventive services

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

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 the PA had no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS 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