Office of Children and Family Services

# Child Fatality Report

## Report Identification Number: NY-17-027

## Prepared by: New York City Regional Office

## Issue Date: Jul 25, 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 | PS-Parent Sub |
| CH/CHN-Child/Children | | |
| **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-Cardiopulmonary 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-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 | |

## Case Information

**Report Type:** Child Deceased **Jurisdiction:** Kings **Date of Death:** 03/13/2017
**Age:** 1 year(s) **Gender:** Male **Initial Date OCFS Notified:** 03/13/2017

## Presenting Information

The 3/13/17 SCR report alleged, the SC was brought to the hospital dead on arrival after being in the care of the parents. On 3/12/17, the SM put the SC to sleep after dinner at approximately 7:00 PM as usual. The SC began to cry around 4:00 AM. The SM went to check on the SC and the SC was warm to touch. The SM did not take the child's temperature although he had a cough and cold for two days. When the SM awoke at 7:00 AM on 3/13/17, she found the SC face down and unresponsive. EMS was called but were unable to resuscitate the SC. Aside from the cough and cold, the SC was an otherwise healthy child at the time of his death.

## Executive Summary

This 1-year-old SC died on 3/13/17. According to the ME, an autopsy was performed and the SC's cause of death was pending. As of 7/24/17, NYCRO has not yet received the autopsy report.

The allegations of the 3/13/17 SCR report were DOA/Fatality and IG of the SC by the parents.

The ACS Specialist interviewed the parents regarding the circumstances surrounding the death of the SC. According to the SF, about two days prior to 3/13/17, the SC started coughing. On 3/12/17 the parents had a regular day with the SC. The parents had recently started the SC on whole milk. The SC was fed a balanced dinner that consisted of a starch, protein, vegetable and fruit. Around 9:00 PM the SC was placed in the crib to sleep. On 3/13/17, around 4:30 AM the SC began to cry. As a normal routine, the SC drank water and fell asleep. The SC did not feel unusually warm when he woke up and the parents did not note a reason to take the SC's temperature. At approximately 7:40 AM, the SM went into the SC's room and observed the SC was faced down in the crib and near his head was a blood stained pillow next to him. The SM alerted the SF and the SF observed the SC was unresponsive and blue in color. The SM called 911 around 7:45 AM. The SM received CPR instruction from the emergency operator and the SF performed CPR on the SC until EMS arrived and took over CPR. Via ambulance, EMS escorted the SC to the hospital where resuscitative measures were continued with no success. The SC was pronounced dead at 8:40 AM in the Woodhull Hospital.

The home was observed to be clean and free of hazards. There was an adequate sleeping arrangement for the SC as the ACS Specialist observed a crib in the home. According to the parents, the SC was born healthy and had no medical issues. The SM stated the SC had developed a series of illnesses when the SC began attending DC. The parents withdrew the SC from DC and hired a nanny to care for the SC. The parents noticed an improvement in the SC's health since they took the SC out of DC. There were no concerns related to safety due to there not being any other children or surviving siblings in the household at the time of the incident.

During the investigation, ACS gathered pertinent information about the SC's death, observed the family's apartment, and obtained accounts from the parents, nanny, medical specialists, LE staff, ER staff and collateral contacts. The investigation revealed the parents had no prior CPS, criminal, domestic violence, mental health or substance abuse history. ACS made diligent efforts to engage the parents as the parents decided to grieve privately away from the home. The parents did not inform ACS of their return; therefore, it was unclear if ACS offered bereavement, burial or funeral services to the parents.

As of 7/24/17, ACS had not yet completed the investigation.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
    - **Safety assessment due at the time of determination?** 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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

**Explain:**
As of 7/5/17, ACS had not yet made a determination of the report.

| | |
|---|---|
| **Was the decision to close the case appropriate?** | Unknown |
| **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:**
N/A

**Required Actions Related to the Fatality**

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

| | |
|---|---|
| **Issue:** | A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment. |
| **Summary:** | The 24-Hour Child Fatality Summary Report was not approved within the required 24-hour timeframe. The SCR report was dated 3/13/17 and ACS approved the 24-Hour on 3/16/17. |
| **Legal Reference:** | CPS Program Manual, VIII, B.1, page 2 |
| **Action:** | ACS must submit a performance improvement 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. |
| | |
| **Issue:** | Failure to Offer Services |
| **Summary:** | During the investigation, the parents ceased all communication with ACS. The documentation did not reflect whether ACS attempted to offered services to the parents during the initial interview or via mail. |
| **Legal Reference:** | SSL 424(10); NYCRR 428.6 |
| **Action:** | ACS must submit a performance improvement 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:** 03/13/2017 **Time of Death:** 08:40 AM

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

**County where fatality incident occurred:** Kings
**Was 911 or local emergency number called?** Yes
**Time of Call:** 07:48 AM
**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:**

- [x] 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 1
**At time of incident supervisor was:** Not impaired.

**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 | Deceased Child | Alleged Victim | Male | 1 Year(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 31 Year(s) |
| Deceased Child's Household | Mother - | Alleged Perpetrator | Female | 31 Year(s) |

### LDSS Response

On 3/13/17, LE responded to the home. LE escorted the parents and the unresponsive SC to the hospital. LE reported the SC had no visible signs of trauma. There was no criminality found at the time as there was no obvious cause of death. There were no surviving children and the parents had no criminal history.

During the interview, ACS observed the parents were behaviorally and cognitively capable to care for the SC. The parents

said the SC was born healthy and had a series of illnesses after the parents enrolled the SC in daycare. The SF stated in late November 2016, the SM took the SC abroad where the MGM assisted the SM in the care of the SC until the SM returned to the USA in January 2017. The family hired a nanny to provide care of the SC after the SM and SC returned from abroad in January 2017. Shortly after the nanny began to care for the SC, he showed no signs of illness. The parents had no issues regarding the level of care the nanny provided the SC. The SF stated about two days prior to 3/13/17, the SC had been coughing. The parents stated the SC was teething.

According to the nanny, she last cared for the SC on 3/10/17. She said the SC appeared well and in good spirits. The nanny acknowledged that beginning January 2017, she provided care of the SC from Monday to Friday from 8:15 AM to 6:30 PM. The nanny said the parents hired her due to the SC's frequent illnesses while enrolled in DC. The nanny stated the SC had not coughed or had a fever at any time she cared for him. The nanny had no concerns regarding the care the SC received by the parents.

On 3/15/17, the SC's medical Dr. said the SC was last seen on 1/11/17 for an annual well-child examination. The SC's immunizations were up to date and the cough had improved. There were no concerns noted. The SC's first visit to the Dr.'s office was in April 2016 after the parents' decision to change the SC's physician. The Dr. said the SC was diagnosed with a medical condition at 8 months old when the family was abroad. On 10/27/16, the SC was seen for a cough and the tests results were negative. On 10/28/16, the parents took the SC to the Dr. who told the parents to take the SC to the ER. The ER attending Dr. repeated tests and the SC was diagnosed with a medical condition. The attending Dr. prescribed medication and released the SC to the parents. The SC's health condition had improved at the time of the 11/9/16 follow-up appointment. On 11/28/16, the SC returned to the family Dr. due to illness. This Dr. examined the SC and advised the parents to give the SC an over the counter (OTC) medication. The SC was given a referral to a medical specialist (MS).

According to the MS, the SC was first seen in December 2016 due to severe coughing. The SC had a cough and the parents treated with OTC medicine. The MS stated the SC's exam was normal. On 1/13/17, the MS saw the SC for a follow-up appointment. The SC was doing well, had no cough and received a vaccination. The MS stated there were no medical concerns nor medication prescribed, and no scheduled follow-up appointment.

The Specialist interviewed the DC provider who said the SC was enrolled on 7/1/16 as a full-time student and was unenrolled on 12/13/2016. The DC staff stated the SC regularly attended with the exception of a few sick days. The staff did not have the documentation of the specific dates. The DC had no issues or concerns regarding the care the parents provided the SC.

ACS made pertinent collateral contacts. According to the EMS records, the 911 call was received at 7:48 AM and the EMS was dispatched at 7:50 AM. The EMS Unit arrived to the home at 7:53 AM and transported the SC to Woodhull Hospital at 8:12 AM. A neighbor and a staff member in the family's building stated the SC was seen in the care of the parents and there were no concerns regarding the SC's care by the parents. Friends of the parents spoke highly of the parents and their interaction with the SC.

## 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 |
|---|---|---|---|
| 036309 - Deceased Child, Male, 1 Yrs | 036311 - Father, Male, 31 Year(s) | Inadequate Guardianship | Pending |
| 036309 - Deceased Child, Male, 1 Yrs | 036310 - Mother, Female, 31 Year(s) | DOA / Fatality | Pending |
| 036309 - Deceased Child, Male, 1 Yrs | 036311 - Father, Male, 31 Year(s) | DOA / Fatality | Pending |
| 036309 - Deceased Child, Male, 1 Yrs | 036310 - Mother, Female, 31 Year(s) | Inadequate Guardianship | Pending |

**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?** | ☒ | ☐ | ☐ | ☐ |

**Fatality Safety Assessment Activities**

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Were there any surviving siblings or other children in the household?** | ☐ | ☒ | ☐ | ☐ |

**Legal Activity Related to the Fatality**

**Was there legal activity as a result of the fatality investigation?** There was no legal activity.

| Services Provided to the Family in Response to the Fatality | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Services** | **Provided After Death** | **Offered, but Refused** | **Offered, Unknown if Used** | **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:**
During the investigation, the parents ceased all communication with ACS. The ACS case record did not reflect whether ACS offered services to the parents during the initial interview or via mail.

**Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?** N/A
**Explain:**
There were no surviving siblings.

## 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?** | N/A |
| **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 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