Child Fatality Report

Report Identification Number: NY-17-090

Prepared by: New York City Regional Office

Issue Date: Feb 26, 2018

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: 1 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 09/14/2017
Initial Date OCFS Notified: 09/14/2017

Presenting Information

The report stated the SC had been sick for the past couple of days. On 9/11/17, the SC fell ill and his parents took him to his primary Dr. who determined the SC had a severe cold. The Dr. instructed the parents to give him medication. At 3:00 A.M. on 9/14/17, the SC woke up coughing and the BF gave him his medicine. At 4:00 A.M., the BF put the SC in his stroller and brought him into the bathroom. The BF turned on the hot water so that the steam would help the SC with his cough. He then left the SC in the stroller in the bathroom unsupervised, closed the door and went back to sleep. At 5:00 A.M., the BM woke up, went into the bathroom to check the SC and found him unresponsive. Emergency Medical Services was contacted and the SC was transported to a local hospital where he was pronounced dead at 5:49 A.M. There was a concern that the SC's exposure to the heat from the steam in the bathroom contributed to his death as his body temperature at the time of his death was 108 degrees.

Executive Summary

ACS documentation revealed the SC was reported to be ill and the parents attempted to administer a home remedy by placing him alone in the bathroom for approximately an hour with the hot water running and the room filled with steam to soothe the SC's respiratory issues. The SC was strapped into his stroller then the parents set an alarm and then went to sleep. At 5:00 A.M., the alarm rang off, the two-year-old male surviving sibling (SS) responded and awoke the parents. When the BM checked on the SC, he was unresponsive. Emergency Medical Services was contacted and a local religious ambulance responded to the home and transported the SC to the hospital where medical staff pronounced him dead at 5:49 A.M. The SC's body temperature at the time of his death was 108 degrees. According to the ME, the SC's cause of death was hyperthermia due to environmental exposure. The contributing factor was broncho pneumonia, complicating viral upper respiratory tract infection. The manner of death was accidental.

On 9/14/17, ACS received the SCR report and initiated the investigation by contacting LE and medical staff. The information obtained from the medical staff revealed the SC was not seen on 9/12/17 by his Dr nor was the use of a nebulizer or hot water steam suggested by the Dr as reported to ACS by the parents. LE was informed about the ME's discovery.

The parents refused to be interviewed by ACS' however, they had told their attorneys they placed the SC in the bathroom with hot steamy water and left him unsupervised for about an hour as advised by the SC's Dr. Following the fatality, the family arranged with the maternal grandparents to temporarily care for the SS.

During the investigation, ACS held a child safety conference (CSC) and participants at the CSC recommended family court intervention to protect the SS. Consequently, ACS filed an Article 10 Petition in Kings Family Court against the parents. The court granted the release of the SS to the maternal grandparents with supervised visits.

On 11/13/17, ACS substantiated the allegations of the report against the parents. ACS based its decision on the information obtained during the investigation which indicated the parents used poor judgment and decision-making skills in their response to the SC's respiratory issues. The SC was not taken to the Dr. and instead was left alone in a steamy bathroom for about an hour, which led to his death. Also, the SS had access to enter the hot steamy bathroom where he observed his brother unresponsive.

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? 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:
The case was opened for services. The SS was in receipt of occupational and speech therapy at his DC. The parents were in receipt of services through a community based organization. The family's Rabbi was also assisting the family to obtain mental health assessments and bereavement groups.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/14/2017 **Time of Death:** 05:49 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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: Placed in the bathroom

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:

- ☐ 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	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

On 9/14/17, ACS contacted the LE, the ME, hospital staff and the SC's Dr. The information obtained from the collaterals revealed the parents did not take the SC to his Dr. as they previously reported. The SC's Dr. stated he had not seen the SC in the days prior to his death and no medical advice was provided to the family.

On 9/15/17, the ACS Specialist visited the case address and attempted to interview the parents but they refused to be interviewed. The parents were advised by their attorney not to speak with ACS; however, the parents allowed the Specialist to assess the home. ACS determined there were no concerns regarding the home environment. On the same date ACS filed an article 10 Neglect petition against the parents in Kings County Family Court. The SS was to reside with the MGM and the parents would have only supervised visits with the SS.

On 9/15/17 and 9/18/17, ACS visited the grandparents' home and assessed the SS to be safe. ACS documented the SS appeared to be comfortable in the home.

Also on 9/18/17, the ME reported the preliminary autopsy did not reveal any trauma to the SC. The Dr. stated the SC's diagnosis was hyperthermia and the case was being assessed as a homicide; however, there was no suspicion of intentional harm to the SC pending further investigation.

On 9/26/17, the SS' DC provider did not report any concerns for the SS. The DC provider described him as a happy child

who was well-cared for. The SS received speech therapy when he was with the DC provider and was documented to be making progress.

On 9/27/17, LE was contacted and reported that there was no arrest and no criminality involved in the SC's death.

On 9/28/17 and 10/16/17, ACS provided the family with referrals to several service providers for bereavement counseling.

On 11/6/17, the ME reported two previous head injuries to the SC which were discovered during autopsy. The ME informed the LE about the findings but stated further assessment was needed to determine whether the injuries were accidental.

Between 9/30/17 and 11/8/17, ACS maintained bi-weekly contacts with the SS. He was doing well in the MGM's home. He had supervised visits with his parents which were monitored by the grandparents and ACS. He was also in receipt of occupational and speech therapy at his DC and was progressing well. There appeared to be no safety concerns for the SS.

On 11/8/17, the family's Rabbi reported the parents were receiving parenting skills training through a community based organization. The Rabbi was also assisting the family with finding mental health assessments and bereavement groups.

On 11/13/17, ACS substantiated the allegations of the report against the parents. The Article 10 Petition against the parents also remained active in Family Court.

On 12/7/17, the ME reported that the findings at the final autopsy revealed the SC's cause of death was hyperthermia due to environmental exposure. The contributing factor was Broncho pneumonia, complicating viral upper respiratory tract infection. The manner of death was accidental.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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 approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: New York City does not have an 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
040841 - Deceased Child, Male, 1 Yrs	043189 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
040841 - Deceased Child, Male, 1 Yrs	043189 - Mother, Female, 22 Year(s)	Lack of Supervision	Substantiated

040841 - Deceased Child, Male, 1 Yrs	043189 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
040841 - Deceased Child, Male, 1 Yrs	040843 - Father, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
040841 - Deceased Child, Male, 1 Yrs	040843 - Father, Male, 27 Year(s)	DOA / Fatality	Substantiated
040841 - Deceased Child, Male, 1 Yrs	040843 - Father, Male, 27 Year(s)	Lack of Supervision	Substantiated
043188 - Sibling, Male, 2 Year(s)	043189 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
043188 - Sibling, Male, 2 Year(s)	040843 - Father, Male, 27 Year(s)	Lack of Supervision	Substantiated
043188 - Sibling, Male, 2 Year(s)	040843 - Father, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
043188 - Sibling, Male, 2 Year(s)	043189 - Mother, Female, 22 Year(s)	Lack of Supervision	Substantiated

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?	☒	☐	☐	☐
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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS filed an Article 10 Petition in Kings Family Court against the parents to protect the SS. The court granted the release of the SS to the maternal grandparents with the parents to have supervised visits.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/15/2017	There was not a fact finding	There was not a disposition
Respondent:	040843 Father Male 27 Year(s)	
Comments:		

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	☐	☐	☐	☐	☐	☒	☐

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 was in receipt of occupational and speech therapy at his day care provider.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents received services through community based organizations.

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

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 did not have any CPS history prior to the 9/28/15 report.

Known CPS History Outside of NYS

The family did not have any 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

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