Child Fatality Report

Report Identification Number: NY-17-137

Prepared by: New York City Regional Office

Issue Date: May 22, 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: 3 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/12/2017
Initial Date OCFS Notified: 12/12/2017

Presenting Information

On 12/12/17, the SCR registered a report alleging DOA/Fatality, Inadequate Guardianship and Lack of Supervision of the one-year-old male subject child. The SC's BF was the subject of the report.

The narrative of the report stated the BF saw the SC alive at approximately 8:00 A.M. on 12/12/17. At about 9:59 AM, the BF called EMS regarding the SC's health. EMS responded to the home and transported the SC to the hospital around 10:36 AM. The SC did not have any pulse and was dead on arrival at the hospital. The report further stated the location of the BF and the SC in the home at the time of death was unknown. The SC was a healthy child and there were no known preexisting medical conditions.

Executive Summary

The three-month-old male SC died on 12/12/17 while in the care of his parents. The ME determined the SC's cause and manner of death was undetermined. According to ACS documentation, the SF saw the SC alive at approximately 8:00 A.M. At 9:50 AM, the BM awoke and noticed the SC was unresponsive. The BM called the SF who immediately called 911. EMS responded to the home minutes later, worked on the SC and then transported him to the hospital. The SC did not have any pulse and was dead on arrival at the hospital.

The SC's two-year-old surviving sibling(SS) resides in the home with the parents.

On 12/12/17, ACS received the report and initiated the investigation by contacting the ER Dr., LE, and EMS personnel. The information obtained from these collateral contacts reflected the SC had been ill for approximately one week prior to his death. ACS established the parents acted appropriately by taking the SC to his primary Dr. multiple times and also obtained a second opinion about his medical condition from another medical provider. The SC's condition did not improve before his death on 12/12/17. The ME did not complete an autopsy at the family's request; however, the ME stated that an external examination of the SC's body did not reveal any signs of trauma or abuse.

The SS did not have any medical or known developmental issues. Throughout the investigation, ACS assessed the SS and determined there were no indications that he was unsafe in the care of his parents. The family declined ACS' referral for bereavement counseling services. They stated they were handling the loss of their son well and had the support of their community and extended family.

On 3/8/18, ACS unsubstantiated the allegations of DOA/Fatality of the SC by the SF. According to ACS, all collaterals including hospital staff, the ME and LE determined there was no evidence of any maltreatment by the SF.

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:
Throughout the investigation, ACS assessed the SS and determined there were no indications he was unsafe in the care of his parents. The family declined ACS' referral for bereavement counseling services.

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: 12/12/2017 **Time of Death:** 11:04 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 09:55 AM
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

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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	No Role	Female	23 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

On 12/12/17, ACS contacted the ER Dr., LE, and EMS personnel. They did not report any concern that the SC was abused or maltreated.

On the same date, ACS visited the family for an assessment of the SS and interview. The family reported the SC became ill on the night of 12/6/17. He was seen by his Dr. on 12/7/17 and diagnosed with a viral stomach condition. He was discharged home with symptomatic care. The SC's condition did not improve and the parents followed up with the Dr. who advised them to continue with the original treatment plan. On 12/8/17, the parents took the SC to another Dr. for a second opinion. The Dr. provided the same diagnosis and treatment plan for the SC. At approximately 8:00 AM on 12/12/17, the SF saw the SC alive in his stroller. The family reported the SC usually slept lying flat on his back in his crib but because of his stomach condition, he was placed in the stroller to keep him upright so that he would not strangle if he vomited. They denied the SC's face and mouth were obstructed by a person or object. The family also denied the SS witnessed EMS attempting to resuscitate the SC because EMS did not allow the family in the bedroom. ACS assessed the SS and deemed him safe in the home with the parents at the time of the visit. The family reported having support from their family and community.

On 12/13/17, the children's primary Dr. stated the SC had been ill from his very first well-visit on 9/25/17 and subsequently at every follow-up visit. The SC was prescribed medication and the parents were coached on how to care for the SC. The Dr. did not report any history of chronic ill-health or frequent medical visits outside what was considered routine for the SS. The two children did not receive any immunizations.

Later that same day, the ME reported that due to the family's objection (religious reasons), there were no tests conducted on the SC; however, an external examination conducted did not reveal any abuse or trauma to the SC.

On 12/29/17, ACS held a child safety conference (CSC) for the family. During the CSC, the family stated they chose not to have the children vaccinated until they were three years old based on the advice of a "movement" within their religious community. The BM stated the SS eventually received his first set of immunizations a few weeks prior to the incident. The CSC recommended early intervention and bereavement counseling services for the family which they declined.

On 1/18/18, the responding EMS staff told ACS the SC had no pulse, was not breathing, and his pupils were dilated. The SC arrived to the hospital with his upper and lower extremities stiff, and there was no heartbeat.

On 1/22/17, the children's primary Dr. reported that the SS was seen on 11/20/17 for his first set of immunizations.

On 2/21/18, the LE closed the criminal investigation based on the death certificate which ruled the SC's death undetermined.

On the same date, the medical provider who provided a second medical opinion did not report any concerns for the children during their medical visits.

On 2/22/18, ACS obtained the SC's death certificate from the ME which stated the cause and manner of death were undetermined.

Between 1/18/18 and 2/23/18, ACS made casework visits to the family and assessed the SS to be safe in the home. The family did not provide any new information regarding the fatality. The parents reported they were coping well with their loss and did not need bereavement counseling or any other services offered by ACS.

On 3/8/18, ACS unsubstantiated the allegations of the report.

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 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
043081 - Deceased Child, Male, 3 Mons	043083 - Father, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
043081 - Deceased Child, Male, 3 Mons	043083 - Father, Male, 26 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?	☒	☐	☐	☐

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?	☐	☒	☐	☐

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	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	☐	☐	☐	☐	☐	☒	☐

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 family did not have any prior history.

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