Child Fatality Report

Report Identification Number: NY-16-110

Prepared by: New York City Regional Office

Issue Date: May 30, 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: 8 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 11/01/2016
Initial Date OCFS Notified: 11/01/2016

Presenting Information

The report alleged sometime prior to midnight on 10/31/16, the SC died while in the care of her birth parents. The SC was born with a metabolic condition causing abnormal adrenal gland function chronically affecting the salt levels in her body. The SC's condition had resulted in her frequent hospitalizations. Maximal preventive and medical supports were in place to assist the family in managing the SC's condition. The report also stated the BM had a history of delaying seeking requisite medical care for the SC and had been repeatedly reluctant to embrace referred services. The BM had in the past made derogatory statements that it was better if the SC died. On 10/31/16, the BM canceled a scheduled home visit with the SC's visiting nurse, claiming she was out of town. Due to the BM canceling the 10/31/16 scheduled medical service in the home and her history of neglectful actions and statements related to the SC's medical needs, the SC's death was deemed suspicious in nature.

Executive Summary

The SC was born medically fragile with a severe medical condition which resulted in her frequent hospitalizations throughout her eight-month life span. At the time of the SC's death, preventive and medical support services were in place for the family to assist with managing her condition. According to the case records, at about 3:30 A.M. on 11/1/16, the SC woke up crying and fussing. The BM held the SC to comfort her. At about 4:30 A.M., the SC felt cold to a touch and was breathing rapidly and the BM continued to comfort the SC. According to the case records, there was a half hour delay in calling 911 as the birth parents (BPs) were praying over the SC. At 5:00 A.M., the BM called 911. EMS responded to the home minutes later, worked on the SC and then transported her to the hospital. The SC arrived at the hospital in cardiac arrest. The hospital staff unsuccessfully made efforts to resuscitate the SC, and at 6:21 A.M., the staff pronounced her deceased. Due to the SC's fragility and severe medical condition, an autopsy was not conducted but the hospital staff determined the SC's cause of death was cardiac arrest and the manner of death was natural.

The SC had five surviving siblings (SS); ages twelve, ten, nine, five and one-year respectively. The one-year-old SS was diagnosed with the same medical condition as the SC but his condition was not as severe and did not frequent the hospital as often. He was receiving Visiting Nurse Services. The twelve-year-old SS was diagnosed with a terminal condition and received hospice services. Due to a family arrangement, the five and twelve-year-old SS lived with the PA. The PA resided nearby the family and had agreed to help in the care of her nephews due to the BPs having two other sickly children.

ACS initiated the investigation on the same day the report was received. The Specialist contacted the family, LE, medical providers, social workers and service providers involved with the family. The information obtained from these collaterals confirmed the SC's fragile medical condition and frequent hospitalizations. The medical and service providers reported that the BPs were knowledgeable about the children's medical conditions and treatment. The BPs were compliant with the services that were in place for the family. The statements provided by the family regarding the SC's medical condition and the events leading up to her death were consistent. The LE closed the criminal investigation stating that the SC's death was not due to any negligence by the BPs.

On 12/29/16, ACS unsubstantiated the allegations of the report against the BPs. ACS based its decision on the

information obtained from medical providers, social workers and service providers involved with the family which confirmed the SC's death was unconnected with child abuse. She had been sickly since birth and died of natural causes.

During the course of the investigation, ACS made several home visits and casework contacts with the family for the continuous assessment of the SS. At every casework contact, ACS utilized language services to engage family members who communicated only in Spanish. The SS remained safe in the care of their caretakers. The family refused recommended services from ACS; however, the service providers continued to provide appropriate services to the other two medically fragile SS. The ten, nine and five-year-old SS were well and did not have any medical concerns.

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 family refused recommended services from ACS; however, the case was kept open for services and service providers continued to provide appropriate services to the family.

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: 11/01/2016 **Time of Death:** 06:21 AM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 05:00 AM
Did EMS to 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 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	Aunt/Uncle	No Role	Female	33 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)

LDSS Response

On 11/1/16, the Specialist contacted the hospital staff, medical providers, social workers and service providers involved with the family. The direct medical providers and service agency confirmed the SC's fragile medical condition since her birth and her past hospitalizations. They reported that prior to her death, the SC was hospitalized for two weeks. The hospital staff reported that the BPs were knowledgeable about all the children's medical condition and they had been compliant with all medical appointments and service providers.

On 11/1/16, the Specialist visited the case address to assess the family. The BPs provided a time line of events as to what occurred prior to the SC going into cardiac arrest which was consistent with the information that was already known. They reported adhering to the SC's medication and feeding schedule on the day of the SC's death. They did not observe the SC having any identifiable symptoms relating to her disorder. The BM disclosed that the one-year-old SS was diagnosed with the same medical condition as the SC but his condition was not as severe and did not frequent the hospital as often. The twelve-year-old SS was diagnosed with a terminal medical condition in July 2016. He was prescribed medication and the family was advised he should be “kept comfortable” at home.

The PA confirmed she offered to help care for the five and twelve-year-old SS. She stated she was fully aware of the twelve-year-old SS' diagnosis and medication regime. She denied being overwhelmed caring for the SS. The Specialist observed all the medical equipments and medications for the medically fragile children in the BPs’ and PA’s homes, and documented both homes were safe for the children at the time of the visit.

ACS cleared the PA and her husband. There were no concerns reported.

Also on 11/1/16, the detective reported that the criminal investigation was closed. The findings indicated the SC died of natural causes and it was not the fault of the BPs.

On 11/2/16 and 11/3/16, the Specialist contacted the SS’ school and the school staff did not report any concerns for the family. The twelve-year-old SS’ home school instructor reported the BM was very cooperative and attentive to the SS.

On 11/4/16, the hospital SW reported that the SC's death was pronounced dead at 6:21 A.M. The SC’s cause of death was cardiac arrest.

On 11/7/16, the family’s medical and preventive service providers did not report any concerns about the care the family gave to the children. They described the family as very attentive and cooperative with services provided.

On 11/7/16 and 11/30/16, ACS held child safety conferences (CSC). The CSC recommended that the family maintained connection with familiar service providers. Consequently, the medical and support service providers already in place would continue to work with the family .

Between 11/9/16 and 12/28/16, ACS made several home visits and casework contacts with the family for the continuous assessment of the SS. The SS were deemed safe. They were stable and receiving the appropriate services.

During the same period, ACS made follow up contacts with the medical, preventive service providers and other collaterals to obtain additional information regarding the family. The collaterals did not report any concerns for the BPs’ protective capacity. The caretakers continued to receive necessary services to care for the SS.

On 12/29/16, ACS unsubstantiated the allegations of the report against the BPs.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

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 NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
036341 - Deceased Child, Female, 8 Mons	036342 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
036341 - Deceased Child, Female, 8 Mons	036343 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
036341 - Deceased Child, Female, 8 Mons	036343 - Father, Male, 35 Year(s)	Lack of Medical Care	Unsubstantiated
036341 - Deceased Child, Female, 8 Mons	036342 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
036341 - Deceased Child, Female, 8 Mons	036342 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
036341 - Deceased Child, Female, 8 Mons	036343 - 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?	☒	☐	☐	☐
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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

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:
Prior to the fatality, the family was involved with an array of service providers who had been working with the family. The family refused recommended services from ACS; however, the service providers continued to provide appropriate services to the other two medically fragile SS.

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 prior CPS history.

Known CPS History Outside of NYS

The family did not have any 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