Child Fatality Report

Report Identification Number: NY-18-031

Prepared by: New York City Regional Office

Issue Date: Oct 01, 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 **Jurisdiction:** Kings **Date of Death:** 03/31/2018
Age: 4 year(s) **Gender:** Female **Initial Date OCFS Notified:** 03/31/2018

Presenting Information

On 3/31/18, at approximately 3:00 AM, the SC had difficulty breathing while in the home with her parents. Despite the parents' knowledge of the SC's diagnosis of asthma they delayed seeking medical attention and at 8:38 AM the SC fell unconscious. The father was holding the SC in his arms and went outside to find a police car for assistance. EMS and a nurse from the nursing home across the street performed CPR on the SC. At 9:45 AM, the SC was pronounced dead at the hospital.

Executive Summary

ACS initiated the investigation by contacting the Kings County Hospital Center (KCHC) and confirmed the reported information. The ACS Specialist received information from the hospital staff, LE, EMS and the ME. ACS learned that the SC had a history of Asthma and had been coughing and wheezing. The parents administered Albuterol treatments via a nebulizer; however, the symptoms persisted. On the way to the hospital, outside the home, the SC collapsed and was taken across the street to a nursing home for immediate medical attention. She was given oxygen and an ambulance transported her to KCHC where she was pronounced dead at 9:45 AM on 3/31/18. The SC resided with her parents, four siblings and her MGM. The allegations of the report were DOA/ Fatality, IG and LMC of the SC by the parents.

According to the attending physician, the parents explained the SC awoke at 4:30 AM coughing and they administered a medical treatment every thirty minutes until 6:30 AM. The parents explained they were going to take the SC to the ER but she fell asleep and they did not want to wake her. The SC awoke between 7:00 and 7:30 AM with a persistent cough and wheezing. In the vehicle, on the way to the ER the SC collapsed. The attending physician reported the SC had no indications of abuse or neglect. The physician stated it was not uncommon for families to treat asthmatics at home before resorting to an ER visit. The physician reported the SC last visited the ER on 2/6/18, where she was treated for asthma and released. LE reported the parents took the SC to a nursing home across the street where she was given oxygen. A patrol officer was flagged, EMS was summoned and the SC was transported to the hospital. LE found no criminality.

On 4/9/18, ACS received information from the children's Dr that reflected their immunizations were up to date; however, they had not had their annual checkup. On 4/13/18, checkups were completed. The Dr explained that the parents knew how to use the nebulizer correctly. The Dr commented that the parents were compliant and consistent with the follow up appointments and the children's health care. The parents were especially concerned about the SC's condition. The Dr had no concerns regarding the care the parents provided.

ACS interviewed the parents and all surviving siblings and their accounts were similar. The MGM is unable to speak. The parents reported the siblings displayed signs that they were affected by the SC's death, especially the SC's twin sister. ACS initiated PPRS on 4/20/18 that involved the entire family. Services included bereavement counseling. The parents reported that the family are also receiving counseling through their religious affiliation. The siblings were receiving support from their perspective school staff.

ACS interviewed the SC's school staff who reported they were not aware of SC's condition and there was no inhaler on file for the SC. According to the staff, the SC had never displayed a need for the school to administer treatment.

Throughout the investigation, ACS made several contacts with the ME and was informed the final autopsy was pending at the time of this writing. The assigned Brooklyn DA reported their investigation was pending the outcome of the final

autopsy report.

On 5/30/18, ACS' determination narrative unsubstantiated the allegations of DOA/ Fatality, and substantiated the IG and LMC of the SC by the parents. ACS documented there was no credible evidence to support the allegation of DOA/ fatality and documented that the parents did not intentionally cause the death of the SC, however, the DOA/fatality allegation was substantiated. ACS concluded the parents delayed seeking medical care knowing the SC had been experiencing symptoms for four days with minimal improvement. ACS noted that the school was not aware that the SC suffered from Asthma. The SC succumbed to an Asthma attack on the way to the ER.

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?** No

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:
Services were offered and implemented.

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:
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Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Supervisor Review

Summary:	The investigation determination S/A should have reflected no safety factors. was completed incorrectly and it was approved by the Supervisor. The comments on the S/A are addressing the deceased SC instead of focusing on the surviving siblings.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.
Issue:	Appropriateness of allegation determination
Summary:	The determination narrative and the decision noted on the investigation summary are incongruent. The determination narrative supports unfounding the DOA/Fatality allegation but it was substantiated.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/31/2018 **Time of Death:** 09:45 AM

Time of fatal incident, if different than time of death: 08:30 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 88:45 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	Female	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	45 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	43 Year(s)

LDSS Response

On 3/31/18, ACS responded to a report registered by the SCR regarding the death of the four-year-old female SC who died as the result of asthma while in the parents' care. ACS obtained information from the first responders, ME and hospital staff. ACS contacted the KCHC and learned the SC was pronounced dead at 9:45 AM on 3/31/18. The allegations of the report were DOA/ Fatality, IG and LMC of the SC by the parents. There were four siblings in the home, none with medical conditions or signs of abuse or neglect.

On the same date, the Specialist interviewed the parents and learned the SC had been coughing and "wheezing," for four days. They administered asthma treatments and the SC's wheezing dissipated but the cough remained. On the morning of the fourth day the parents realized the SC's condition had not improved and they placed her in the car to take her to the ER; however, she became unresponsive. The SF took her out of the car seat and flagged a patrol car. The SF then ran with the SC across the street to a nursing home where she was given oxygen; however, she still did not respond. The nursing home nurse contacted 911 and EMS responded and transported the SC to the ER where medical staff declared her dead.

On 4/9/18, the EMS Liaison reported they responded to a call from LE on 3/31/18, at 8:40 AM and upon their arrival, the SC was unresponsive. EMS reportedly arrived at the ER at 9:23 AM. LE reported no criminal action will be taken against the parents. ACS also interviewed collaterals at the nursing home and they reported the nurse administered CPR and oxygen; however, the SC remained unresponsive.

According to both parents, the Dr. recommended the SC use an inhaler two times per day, Albuterol and Budesonide as needed; however, the SC was not taught to use the inhaler pump and the parents did not inform the Dr. the SC was not using the medicine as prescribed. The parents explained that they administered Albuterol only, because it worked best. According to ACS, the Dr. reported the SC's asthma action plan that was explained to the parents, was to administer the medications via nebulizer for two to three treatments as needed and if there was no improvement, the SC should be brought to the Dr. The parents reported the SC was usually affected by the condition during the nights and early mornings.

ACS interviewed the surviving siblings individually and there were no inconsistencies regarding the events of the days leading up to the incident. The children's school records reflected the surviving siblings had been performing on grade level with no attendance issues. According to the surviving siblings medical records, they needed annual checkups to be current with their immunizations. The examinations were completed on 4/13/18, after ACS' involvement. The surviving siblings continued to reside with the SM and although the SF resided at a separate address, he provided most of the care to the children due to the SM's work schedule.

On 4/20/18, the family signed for PPRS and was reported to be complying with services and doing well. ACS provided burial assistance. ACS made two successful contacts to an out of state agency and requested a courtesy visit; however, ACS did not receive the child safety assessment.

On 5/30/18, ACS substantiated the allegations of IG and LMC of the SC by the parents. ACS determined that there was credible evidence that the parents delayed in seeking medical attention and the SC succumbed to an asthma attack on the way to the ER.

On 5/30/18, ACS' narrative documented that they intended to unsubstantiate the DOA/ Fatality allegation. ACS determination narrative found no credible evidence to support the allegation of DOA/Fatality and documented that the parents did not intentionally cause the death of the SC. However, the CPS Investigation Summary reflected the allegation DOA/ Fatality was substantiated.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: From a 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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045341 - Deceased Child, Female, 4 Yrs	045344 - Father, Male, 43 Year(s)	Lack of Medical Care	Substantiated
045341 - Deceased Child, Female, 4 Yrs	045342 - Mother, Female, 45 Year(s)	DOA / Fatality	Substantiated
045341 - Deceased Child, Female, 4 Yrs	045344 - Father, Male, 43 Year(s)	DOA / Fatality	Substantiated
045341 - Deceased Child, Female, 4 Yrs	045342 - Mother, Female, 45 Year(s)	Inadequate Guardianship	Substantiated
045341 - Deceased Child, Female, 4 Yrs	045342 - Mother, Female, 45 Year(s)	Lack of Medical Care	Substantiated
045341 - Deceased Child, Female, 4 Yrs	045344 - Father, Male, 43 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

	Yes	No	N/A	Unable to Determine
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	☒	☐	☐	☐

Explain:
The family accepted and initiated PPRS on 4/31/18.

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?	☐	☒	☐	☐

Explain as necessary:
The Specialist chose Decision # 5; however, there were no Safety Factors present to place the surviving siblings in danger and according to ACS, the siblings were deemed safe and remained in the home with the SM.

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	☐	☐	☐	☐	☐	☒	☐

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 family agreed to engage in PPRS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The surviving siblings showed signs that the SC's death had an affect on them and because of this the parents accepted 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

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

In 2012, the SF filed for custody of two of his children (from a previous relationship). Bronx Family Court ordered an investigation. ACS documentation revealed the visitation order of custody was modified and the case was closed. The children now reside in another state with their mother.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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