Child Fatality Report

Report Identification Number: NY-18-055

Prepared by: New York City Regional Office

Issue Date: Nov 13, 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: 2 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 03/29/2017
Initial Date OCFS Notified: 06/01/2018

Presenting Information

The 6/1/18 SCR report alleged about two years ago, the 2-yo SC passed away for unknown reasons. The SC was otherwise healthy making the death suspicious. The SM and SF both had access to the SC at the time of the death.

The 6/1/18 report alleged the family had another child who died for unknown reasons.

Executive Summary

The 2-yo male child (SC) died on 3/29/17. The Office of the Chief Medical Examiner of the state of Maryland listed the manner and cause of death as undetermined.

Following the SC's death, the SCR registered a report regarding the family on 9/6/17. The allegations of the 9/6/17 report were IG and LMC of the 10-month old surviving CH by the SM. ACS investigated the report and opened a preventive services case for the family to address the 10-month-old CH's prematurity and medical needs. On 10/30/17, ACS Unsub the allegations of the 9/6/17 report. ACS closed the preventive services case on 3/16/18 after the family refused services and Family Court Legal Service (FCLS) determined there was no basis to file a case in Family Court.

Between April 2018 and May 2018, the family had no involvement with the SCR and ACS.

On 6/1/18, the SCR registered a report that included the allegations of DOA/Fatality, IG and LS of SC by the SF and DOA/Fatality and IG of the one-month old female infant by the SM and SF. NYCRO issued a separate Individual Child Fatality in regard to the death of the one-month-old female infant.

The SM denied the allegation of the 6/1/18 report and said the SC died in Maryland. According to the SM's account, the SC became ill during the night prior to the date of death and the family transported the SC to the hospital. An attending physician examined the SC and discharged him to the parents. The SM said the family came home from the hospital at 4:00 AM that morning prior to the SC's death. A couple of hours later, the SC became ill again. Upon arriving at the hospital at 4:00 PM the SC was pronounced dead. The SF provided an explanation about the SC's death and the details of the events was similar to the SM's account that was previously documented in the ACS case record. The SF explained that he took the SC to the hospital and an attending physician told him the SC's medical condition would improve and discharged the SC. The SM and SF returned home with the SC at 4:00 AM, but later in the day they observed the SC was ill. They returned the SC to the hospital at 4:00 PM the same day, but upon arriving at the hospital the SC died. The SF said LE was contacted and he was interviewed by LE and Maryland CPS.

On 7/26/18, a supervisor with the Baltimore Child Protection Family and Children Service (BCPFCS) informed ACS that the SC died due to natural causes.

ACS verified the SM and SF had two surviving CHN (6-yo-male and 10-month-old female) in their household composition. The 10-month-old CH was medically fragile and received treatment of illness. On 8/6/18, ACS opened a preventive services case due to concerns that the family had two CHN who had died in the past due to various health reasons. ACS explained that the family had a 10-month old CH who was ill and a 6-yo CH in the home. The Family Service Progress Notes reflected that after the family returned to reside in Maryland, ACS closed the preventive services case on 9/24/18.

On 8/8/18, ACS Unsub the allegations of DOA/Fatality, IG and LS of the SC by the SF. ACS based the determination on evidence that showed the SC's death was undetermined as per the Chief Medical Examiner in Maryland. The SM and SF reported and medical documentation reflected the SC had a medical condition a few days prior to passing away at the hospital in Maryland. There was no evidence that showed the SF failed to provide a minimum degree of care to the SC. The SC did not die in NYC and was not left unsupervised in the café.

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:
NA

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: 03/29/2017 **Time of Death:** 05:41 PM

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

Was 911 or local emergency number called? Unknown
Did EMS respond to the scene? Unknown
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
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	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	No Role	Female	20 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

On 6/1/18, upon receipt of the SCR report, ACS contacted LE to discuss the case circumstances. ACS learned that there was an incident report regarding a CH drinking alcohol at the bar alongside his father (the father's name was not the same as the SF's, that was identified in the 6/1/18 ACS investigation.) There was a second report in 2016 but there were no CHN reported.

ACS interviewed the owner of the café who denied there was an incident involving a CH drinking alcohol in the café/bar. On 6/4/18, ACS visited the café and observed the SF. ACS advised the SF of the allegations of the report and attempted to interview him regarding his knowledge of the case circumstances. The SF said he resided in Maryland. He said he did not want to continue with the interview.

On 6/28/18, ACS met with an external resource who assisted with identifying and locating the family. ACS learned that the SC was hospitalized for treatment of illness and died in the hospital. The SM had a 1-month-old female infant who died in 2016 due to natural causes, and the 10-month-old surviving CH had similar health issues as the deceased infant and SC.

ACS interviewed a hospital social worker (SW) who said the 10-month old CH was admitted to the hospital on 2/7/18 for a medical condition. The CH received medical care with different medical specialists. The medical records showed two of the SM and SF's children died due to illnesses. Later, a SW reported there were no concerns regarding the care of the 10-

month-old CH by the SM and SF.

On 7/3/18, ACS visited the home and interviewed the SM and SF. The SM provided a hospital discharge document that was dated 3/23/17 and issued by a hospital in Brooklyn. The hospital document showed the SC was examined for an illness and then released to the parents. According to the SM's account, the family then returned to Maryland. The SM and SF took the SC to the hospital in Maryland at approximately 4:00 AM on 3/29/17, the SC's condition was stable and the attending physician discharged the SC to the SM and SF. The SM said the physician did not prescribe medication. The SM said that on 3/29/17, at about 4:00 PM, she returned the SC to the hospital where he was pronounced dead. The SM provided a Certificate of Death for the SC.

On 7/31/18, ACS referred the case to FCLS for a legal consultation and the FCLS attorney said there did not appear to be a legal basis to file an Article Ten Neglect petition. The hospital staff had no concerns regarding the 10-month-old CH and the 6-yo CH seemed to have received adequate care.

On 7/31/18, ACS interviewed the BCPFCS staff who investigated the death of the SC. The CW said the cause of death per the ME was undetermined. ACS learned that the SM took the SC to the hospital in Maryland with a fever due to a medical condition as per the medical notes on 3/28/17. The SC was treated and discharged. The SM returned the SC to the hospital on 3/29/17. The SC died at the hospital.

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 previously approved protocols for joint investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048140 - Deceased Child, Male, 2 Yrs	048181 - Father, Male, 25 Year(s)	Lack of Supervision	Unsubstantiated
048140 - Deceased Child, Male, 2 Yrs	048181 - Father, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
048140 - Deceased Child, Male, 2 Yrs	048181 - Father, Male, 25 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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:
The SC died in Maryland.

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 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?	☐	☐	☒	☐

Explain:
ACS made diligent efforts to locate the family; however, the agency was unable to do so within within 24 hours of notification of the SC's death.

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	☒	☐	☐	☐
Explain: ACS documentation reflected the family would be referred to PPRS to address identified medical needs.				

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: PPRS							
Additional information, if necessary: The family agreed to accept preventive services to address medical needs.							

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? Unable to Determine
Explain:
The SC died on 3/29/17. The death occurred prior to ACS involvement with the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The 2-yo SC died on 3/29/17. The SC died prior to ACS involvement with the family.

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 parents were not know to the SCR or ACS three years prior to the fatality.

Known CPS History Outside of NYS

According to ACS, the parents were known to Baltimore Child Protection Family and Children Services in a report that involved the SC's death. LE interviewed the SF and no arrests were made. The cause of SC's death was listed as undetermined. The family had another investigation that involved the allegation of medical neglect of the 10-month old CH. The report was IND, but the SM and SF relocated to New York in November 2017, and the case was referred to ACS for follow-up as the family had a service case. The Montgomery County Child Protective Services was made aware of the family circumstances when the infant passed away. The cause of death was undetermined.

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