Child Fatality Report

Report Identification Number: NY-18-066

Prepared by: New York City Regional Office

Issue Date: Dec 12, 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 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 06/18/2018
Initial Date OCFS Notified: 06/19/2018

Presenting Information

The report alleged between 6/15/18 and 6/17/18, the family traveled out of town. While out of town, the SC caught a cold. She had a fever of 103 degrees and vomited multiple times. On 6/17/18, the parents gave the SC medication; her fever subsided and they returned home. On 6/18/18, the BF stayed home with the SC to monitor her while the BM went to work. At an unspecified time, the BF put the SC down for a nap and she slept for an unknown amount of time. The BF went into the bedroom to check on the SC and found her unresponsive. The BF rushed the SC to the nearest NYPD Precinct where the LE staff revived the SC. She had a pulse and was then transferred to the hospital for further medical attention. Upon arrival, hospital staff made unsuccessful efforts to resuscitate the SC. At 10:47 PM, the hospital staff pronounced the SC deceased. She was an otherwise healthy child.

Executive Summary

On 6/18/18, the SC passed away while in the care of her BF. A review of the case records revealed between 6/15/18 and 6/17/18, the SC had been ill while on a family trip out-of-state. At approximately 6:00 PM on 6/18/18, the BF noticed the SC was blue. The BF rushed the SC to the nearest NYPD precinct where she was resuscitated. She had a pulse and was taken to a neighborhood hospital for further medical attention. The SC was transferred to a specialized hospital for higher level medical care where hospital staff made efforts to resuscitate her without success. At 10:47 PM, the hospital staff pronounced the SC deceased. The SC's cause and manner of death remained pending at the time of this writing report. The SC did not have any surviving siblings.

On 6/19/18, ACS initiated the CPS investigation and contacted LE and hospital staff, and interviewed the family. The LE, and hospital staff did not report any signs of abuse to the SC. Also, LE assessed the family's home and did not observe any concerns. Based on the findings, LE did not record any criminality regarding the SC's death and no arrest was made. The biological parents (BPs) provided a descriptive account about the family's trip out-of-state and how the SC felt throughout, which included the number of times the SC vomited and felt lethargic. The BPs gave the SC medication and fluids to keep her hydrated, in addition to taking her temperature every few hours. The BPs reported that the SC was in excellent health, and did not have any medical condition prior to her death.

During the investigation, ACS completed investigative clearances on the family. The family did not have any CPS or criminal history; however, the case records reflected the BPs had resided in New Jersey and Texas prior to living in New York City. Consequently, ACS contacted New Jersey Division of Child Protection and Permanency and requested clearances for the BM, and Texas Department of Family and Protective Services about the BF. There were no findings for the BPs.

ACS offered the BPs bereavement counseling services. They reported they were doing well and were exploring bereavement services on their own.

At the time of writing this report, the ME had not determined the SC's cause and manner of death. Also, ACS had not determined the CPS investigation. On 11/23/18, NYCRO CPS contacted ACS via email regarding the determination of the investigation. ACS had not responded to the email.

PIP Requirement

A PIP is required for this fatality investigation. The issues noted were: Timely/Adequate Case Recording/Progress Notes and Adequacy of Child Protective Services casework contacts.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS had not made a determination of the CPS investigation.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Progress notes were not updated contemporaneously and were months behind.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Adequacy of Child Protective Services casework contacts
Summary:	ACS failed to contact the SC's daycare provider.
Legal Reference:	432.2(b)(4)(vi)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/18/2018 **Time of Death:** 10:47 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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	Female	3 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Mother	No Role	Female	48 Year(s)

LDSS Response

On 6/19/18, ACS contacted LE and hospital staff. The hospital staff did not report any signs of abuse to the SC. There was a concern that the SC ingested the BF's prescribed medication for his heart condition due to the SC's high heart rate; however, a blood screening was done on the SC and her symptoms were inconsistent with her ingesting the BF's medication. The SC's heart was normal and overall, she was a healthy child. The staff stated it appeared the SC had a viral infection. The LE staff stated the SC was observed to be a well child. She did not have any marks or bruises and appeared average size for her age. LE assessed the family's home and did not observe any concerns. The BF's medication was observed to be closed and in a child proof container. The LE staff stated pending the ME's report, there was no criminality regarding the SC's death and no arrest was made.

Also on 6/19/18, ACS visited the family and the biological parents (BPs) provided a descriptive account of the family's trip out-of-state. The BPs gave the SC medication and fluids to keep her hydrated, in addition to taking her temperature

every few hours. The BPs reported that the SC was in excellent health, and did not have any medical condition prior to her death.

On 6/20/18, the BM's friend described the BM as an outstanding caring and a devoted mother. She did not report any concerns about the care the BM provided the SC.

Between 6/25/18 and 7/19/18, ACS made multiple contacts with the ME regarding the autopsy findings. The ME stated the autopsy was pending toxicology results.

On 7/19/18, the family reported the SC was buried in Texas. ACS did not document any new information regarding the family and no issues were noted. ACS offered the family services for their loss but they declined.

On 7/20/18, the BPs reported they were in Texas for the SC's memorial. They declined ACS' offer of bereavement counseling services and stated they were exploring bereavement services on their own.

At the time of writing this report, the ME had not determined the SC's cause and manner of death. Also, ACS had not yet determined the CPS investigation.

Official Manner and Cause of Death

Official Manner: Pending
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 a 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
046741 - Deceased Child, Female, 3 Yrs	046743 - Father, Male, 47 Year(s)	Inadequate Guardianship	Pending
046741 - Deceased Child, Female, 3 Yrs	046743 - Father, Male, 47 Year(s)	DOA / Fatality	Pending

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?	☐	☒	☐	☐
Public or Private Child Care	☐	☐	☐	☒
Caretakers / Babysitters	☐	☐	☐	☒
Daycare Provider	☐	☐	☐	☒
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?	☐	☒	☐	☐

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? 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

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