NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-14-131 **Prepared by: New York City Regional Office**

Issue Date: 6/3/2015

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
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	MN-Medical Neglect	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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 12/03/2014
Initial Date OCFS Notified: 12/10/2014

Presenting Information

The narrative stated the SC was born with significant medical conditions which required nursing care in the home seven days a week. Also, she was fed intravenously and as a result, she was susceptible to serious infections from bacteria in the supply lines.

The BM had a history of not following through with the SC's medical appointments and canceling her services with home health care professionals. On 11/17/14 and 11/19/14, the SC was hospitalized because of her condition. On 11/27/14 and 11/29/14, the BM canceled home health care for the SC. On 12/1/14, the SC went into shock and was hospitalized due to her condition. On 12/3/14, she died during her hospitalization. The BM's lack of follow through with medical appointments and canceling the SC's medical home care visits contributed to her death.

Executive Summary

The SC was a medically fragile child who was given palliative end-of-life care when she was born. On 12/1/14, the SC was hospitalized due to her condition and on 12/3/14; she passed away at Kings County Hospital (KCH). The SC had a one-year-old surviving child. The BM and her paramour had the one-year-old child in common. The whereabouts of the SC's BF were unknown at the time of her death.

On 12/5/14, the ACS BFO Specialist contacted the medical staff at KCH and Long Island Jewish Hospital (LIJH), the ME and the detective. They did not report any negligence regarding the SC's death. The Dr. at LIJH described the SC as an extremely ill child from birth and she was not in imminent danger in her BM's care. The Dr. described the BM as a good mother who was very affectionate with the SC. The ME reported that preliminary findings did not reveal any trauma to the SC and the detective stated no arrests had been made.

ACS obtained additional information from visiting nurse services (VNS), the medical consultant and the medical child abuse specialist which did not indicate the BM was negligent in her care for the SC. The VNS' staff confirmed that the SC was provided services seven days a week. The staff also confirmed the BM was trained to provide appropriate care for the SC and there were no concerns about the care she gave her daughter.

Also on 12/5/14, the Specialist visited the case address to assess the family. The BM denied missing the SC's medical appointments at LIJH and stated that the SC was already admitted into the KCH on the days of her appointments. She presented discharge papers from KCH which indicated the SC had been in and out of KCH three weeks prior due to her medical condition. The BM confirmed she received training on how to care for the SC and she was the sole caregiver in the absence of the VNS. The BM declined ACS' offer of services and stated she received support from her family.

The family members did not report any concerns about the BM and her children. They described her as a wonderful mother who would not harm her children. They denied DV, mental illness or substance abuse in the home.

The Specialist observed the surviving child and she appeared safe in the home. The BM denied the child had any medical condition and stated her immunizations were current. Also, the child's pediatrician had denied any concerns

for the child.

Between 12/29/14 and 4/15/15, ACS made several home visits and casework contacts with the family for the continuous assessment of the surviving sibling. The child remained safe in the home. During the visits, ACS consistently engaged the family around preventive services and bereavement services; however, they refused all recommended services.

On 3/11/15, the ME reported that the SC's cause of death was a medical condition due to premature birth. The manner of death was natural. According to the ME, the medical records obtained from VNS and KCH did not reveal there was neglect or maltreatment of the SC.

On 4/17/15, ACS unsubstantiated the allegations of the report against the BM. ACS based its decision on the information obtained from collaterals and medical doctors which confirmed the SC's death was unconnected with child abuse. The SC had been very sick since birth and died of natural cause.

The surviving child was observed and deemed safe in the care of her parents and family members. The family continued to decline offer of services.

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?** No
  - **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.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment

Summary:	ACS did not comply with the 24 hour safety assessment requirement.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with staff involved with this fatality investigation and inform the NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/03/2014 **Time of Death:**

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? No
Did EMS to 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
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Male	24 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	36 Year(s)
Deceased Child's Household	Other Child	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	24 Year(s)

LDSS Response

On 12/5/14, the Specialist contacted the SC's Dr. at LIJH who stated that the SC was stably ill but she was not in imminent danger. The Dr. expressed concerns about the BM's missed appointments for the SC; however, they did not directly impact the SC's health condition or lead to her death. The Dr. described the BM as a good mother who was very affectionate with her daughter.

Following the contact with the Dr., the Specialist visited the family at the case address. The BM denied missing the SC's medical appointments at LIJH and stated the SC was already admitted into the KCH on the days of her appointments. She presented the SC's discharge papers from LIJH which indicated the SC had been in and out of KCH three weeks prior due to her condition. She confirmed she received training on how to care for the SC and she was the sole caregiver in the absence of the VNS. The BM declined ACS' offer of services and stated she received support from her family.

The family members did not report any concerns about the BM and her children. They described her as a wonderful mother who would not harm her children. They denied DV, mental illness or substance abuse in the home.

The Specialist observed the surviving child and she appeared safe in the home. The BM denied the child had any medical condition and stated her immunizations were current.

On 12/8/14, the Specialist visited KCH where hospital staff confirmed that between 6/1/14 and 12/1/14, the SC had five hospitalizations due to her condition. The attending Dr. described the SC as a sickly child who did not have a good prognosis from birth and that the BM was not negligent in her care for the SC.

Later that same day, the Specialist contacted VNS staff who stated that the VNS had provided services to the SC seven days a week since 11/25/13. The staff did not report any neglect or maltreatment of the SC by the BM.

On 12/10/14, the Specialist made a follow-up visit to the case address. The BM disclosed that she received prenatal care at Wyckoff Hospital and gave birth to the SC when she was seven weeks pregnant. Following her birth, the SC was in the hospital for twenty-two months due to her condition. The BM again denied she missed the SC's appointments and stated she was provided car service to transport the SC to her Dr.'s appointments. She presented a notarized letter which authorized VNS nurses to take the SC to the hospital in her absence. There were no concerns for the surviving child during the visit.

On 12/12/14, the Specialist contacted the surviving child's pediatrician who denied any concerns for the child. Also on 12/12/14, the detective reported that no criminality had been established regarding the SC's death and no arrest had been made.

On 12/15/14, the ME reported that preliminary findings on the SC's death did not reveal any trauma to the SC.

Between 12/29/14 and 4/15/15, ACS made several home visits and casework contacts with the family for the continuous assessment of the surviving child. The child remained safe in the home. During the visits, ACS consistently engaged the family around preventive services and bereavement services; however, they refused all recommended services.

On 3/11/15, the ME reported that the SC's cause of death was a medical condition due to premature birth. The manner of death was natural. The ME stated the medical records obtained from VNS and KCH did not indicate there was neglect or maltreatment of the SC.

On 4/17/15, ACS unsubstantiated the allegations of the report against the BM. ACS based its decision on the information obtained from collaterals and Drs. which confirmed the SC's death was unconnected with child abuse. She had been very sick since birth and died of natural cause.

The family continued to decline offer of services; however, the surviving child was observed and deemed safe in the care of her parents and family members.

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: 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: New York City does not have an OCFS approved CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
016801 - Deceased Child, Female, 2 Yrs	016802 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
016801 - Deceased Child, Female, 2 Yrs	016802 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
016801 - Deceased Child, Female, 2 Yrs	016802 - Mother, Female, 22 Year(s)	Lack of Medical Care	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 and 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	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
ACS consistently engaged the family around preventive services and bereavement services; however, they refused all recommended services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family declined services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/05/2014	2861 - Deceased Child, Female, 2 Years	2862 - Mother, Female, 22 Years	Inadequate Guardianship	Unfounded	No
	2861 - Deceased Child, Female, 2 Years	2862 - Mother, Female, 22 Years	Lack of Medical Care	Unfounded	

Report Summary:
The SC was a medically fragile child who was given palliative end-of-life care when she was born. There were concerns

that the BM was not appropriately following-up with the child's specialized medical care and had missed the SC's appointments to see her specialist. The BM failed to follow through with developmental testing to have the SC placed on the New York transplant list and her non-compliance affected the SC's ability to obtain a transplant which could lead to her death.

Determination: Unfounded	**Date of Determination:** 04/17/2015

Basis for Determination:
Medical records obtained from Long Island Jewish Hospital and discharged papers from Kings County Hospital, indicated the SC's missed appointments at Long Island Jewish Hospital were due to the child already being hospitalized at Kings County Hospital.

Also, the Dr. at Kings County Hospital pediatric intensive care unit described the SC as an extremely ill child and did not report any concerns about the care she received from her BM. The BM consistently followed the Dr.'s directive to get the SC to a neighboring hospital when necessary.

OCFS Review Results:
The investigation was conducted appropriately.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

The family did not have any CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family did not have any known CPS history outside of NYS.

Services Open at the Time of the Fatality

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.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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