NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-029 **Prepared by: New York City Regional Office**

Issue Date: 10/27/2015

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: 1 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 04/27/2015
Initial Date OCFS Notified: 04/27/2015

Presenting Information

On 4/27/15, the SCR registered a report concerning the death of the SC. The report noted that on 4/21/15, the SC sustained second and third degree burns while in the care of a licensed practical nurse (LPN) who was providing in-home care to the child. The LPN placed the SC in the tub with hot water. The report also noted that the SC had special needs. The report further noted that the SC died on 4/27/15 due to medical complications involving burns, fever, and sepsis.

Executive Summary

The SC was born premature at 25 weeks gestation weighing 1.8 pounds and was medically fragile. Following her birth, the SC had numerous hospitalizations. As per an agreement between the parents and the MGM, the SC was discharged from Blythdale Hospital to the MGM's home. The SC received 22 hours daily in-home nursing services.

On 4/27/15, the SCR registered a report with allegations of DOA/Fatality and Burns/Scalding of the SC by the LPN. On 4/21/15, the MGM left the SC in the LPN's care. The MGM fed and administered the SC's prescribed medication prior to leaving the home. The LPN gave the SC a second feeding and then decided to bathe her. The LPN alleged that she tested the water temperature prior to placing the SC in the tub. The LPN said she noticed that the SC was shivering and added hot water to the tub. The LPN alleged that she removed the SC from the tub before adding the hot water. The LPN stated that once the water was warm, she placed the SC in the tub; however, she noticed the SC "jumped" when she was placed in the tub. The LPN said she then pulled the SC from the water and saw that the SC's skin was red. The MGM's tenant was entering the home when she found the LPN in a panic attempting to call 911. The tenant took the telephone from the LPN and spoke to the operator. The time of the call was not noted.

EMS responded to the home and found that the SC had 2nd degree burns to the lower half of her body. Medical personnel indicated the burn pattern suggested that the child was submerged in the hot water. The SC was wrapped in a sterile burn dress and then transported to Nassau County Medical Center where she was admitted in critical condition. The SC was diagnosed with 2nd degree burns on 45% of her body and underwent skin graph surgery on 4/24/15. The SC later had a spike in her temperature due to sepsis infection. She was pronounced dead at 10:25 A.M. on 4/27/15.

The ME's verbal report of the manner of death was homicide; however, the cause of death had not been determined. The LPN was arrested on 4/29/15 while trying to leave the US. She was charged with Murder in the Second Degree and remanded to Riker's Island Correctional Facility without bail.

On 6/26/15, ACS substantiated the allegations against the LPN based on her arrest for murder. ACS documented that the LPN's failure to test the water in the SC's tub caused the 2nd degree burns. ACS noted that the LPN had training in caring for a variety of patients and should have exercised better judgment when she bathed the SC.

On 9/9/15, ACS received the autopsy report, which listed the cause of death as pneumonia and sepsis complicating thermal injuries to the body surface (approximately 50 %) and the manner as an accident. It is unknown whether the

charges against the LPN would remain unchanged. The next hearing in the Queens Criminal Court was scheduled for 10/2/15.

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?** 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

Explain:
N/A

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:
N/A

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: 04/27/2015 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 04/20/2015
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: Unknown

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: bathing

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:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☒ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	54 Year(s)
Deceased Child's Household	Other Adult	No Role	Female	65 Year(s)
Deceased Child's Household	Other Adult	No Role	Male	34 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	41 Year(s)
Other Household 1	Father	No Role	Male	34 Year(s)
Other Household 1	Mother	No Role	Female	31 Year(s)
Other Household 2	Other	Alleged Perpetrator	Female	54 Year(s)

LDSS Response

ACS' investigation included contact with the NYPD, medical providers, family members and the ME. ACS learned the SC's in-home nursing services began on 10/20/14; however, the LPN began working with the family on 4/20/15. ACS determined that the LPN was a Person Legally Responsible for the SC as she was assigned to care for the SC without the supervision of family members and for an extended period of time.

On 4/21/15, the MGM left the SC in the care of the LPN to run some errands. The LPN fed the SC at 12:00 P.M. By 2:45 P.M., she began to prepare a bath for the SC. She alleged that she tested the water before putting the SC in the "baby tub." The LPN stated that as she was bathing the SC, she noticed the SC was shivering. Therefore, she took the SC out of the tub and began adding hot water. Once the water was "okay," she placed the SC in the tub again, and the SC "jumped." She

then took the SC out of the tub and noticed the SC's skin was red. The LPN stated she held the SC to her chest and wrapped her in a receiving blanket that she had soaked in cold water. She then ran to the bedroom and called 911. She yelled out for help when she heard the MGM's tenant walk into the home. ACS spoke to the tenant who indicated that when she arrived at the home, the LPN was in a panic. The tenant took the telephone from the LPN and spoke to the 911 operator.

EMS found that the SC had 2nd degree burns to the lower half of her body and wrapped her in a sterile burn dress. The SC was transported to Nassau County Medical Center where she was admitted in critical condition. The SC was diagnosed with 2nd degree burns on 45% of her body. The SC underwent skin graph surgery on 4/24/15 and died on 4/27/15 due to medical complications involving the burns, fever and sepsis infection. ACS contacted the ME who ruled the death as a homicide, but did not provide a cause of death.

The LPN told ACS, NYPD and the medical staff that she did not use gloves to bathe the SC or leave the SC unattended. She could not provide a plausible explanation for the SC's burns as she maintained that she checked the water temperature before placing the SC in the tub. Based on the pattern of the burns, the medical personnel determined that the SC was submerged up to her waist in water temperature of 130 degrees Fahrenheit for about 30 seconds. The NYPD and medical staff found the LPN's account inconsistent with the SC's injuries. The nurse was arrested on 4/29/15 while trying to leave the US. She was charged with 2nd degree Murder and remanded to Riker's Island Correctional Facility without bail.

The management at the nursing agency indicated that the LPN worked for the company since 2009 and there were no concerns about her ability to care for her patients.

The parents who had not met the LPN prior to the incident had no firsthand information to contribute concerning the circumstances that led to the SC's burns. The collateral contacts with friends and relatives did not express any concerns of abuse or maltreatment of the SC by the parents. ACS assessed the MGM's home and observed the SC's room, which had a crib, medical equipment and supplies. The SC had two siblings, from the father's previous relationships, who resided with their mothers. ACS deemed the siblings safe.

On 6/26/15, ACS substantiated the allegations against the LPN based on her arrest for murder. ACS cited that the LPN's failure to test the water in the SC's tub caused the 2nd degree burns. ACS noted that the LPN had training in caring for a variety of patients and should have exercise better judgment when she bathed the SC.

On 9/9/15, ACS received the autopsy report, which listed the cause of death as pneumonia and sepsis complicating thermal injuries to the body surface (approximately 50 %) and the manner as an accident. It is unknown whether the charges against the LPN will remain the same. The next Criminal Court hearing is scheduled for 10/2/15.

Official Manner and Cause of Death

Official Manner: Accident
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 previously 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
017361 - Deceased Child, Female, 1 Yrs	017372 - Other - nurse, Female, 54 Year(s)	DOA / Fatality	Substantiated
017361 - Deceased Child, Female, 1 Yrs	017372 - Other - nurse, Female, 54 Year(s)	Burns / Scalding	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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:
ACS did not interview the SC's pediatrician as the parents refused to sign a HIPAA consent form.

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?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Nurse	Pending	Pending
Comments:	The LPN's next court date is scheduled for 10/2/15.		

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: N/A							

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? N/A
Explain:
There were no siblings or children in the household that required services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
ACS offered the family assistance for the cost of the burial and referrals for bereavement counseling, but they declined.

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)
04/21/2015	3051 - Deceased Child, Female, 1 Years	4513 - Other - Nurse, Female, 54 Years	Burns / Scalding	Indicated	Yes
	3051 - Deceased Child, Female, 1 Years	4512 - Father, Male, 34 Years	Inadequate Guardianship	Indicated	
	3051 - Deceased Child, Female, 1 Years	4511 - Mother, Female, 31 Years	Burns / Scalding	Unfounded	
	3051 - Deceased Child, Female, 1 Years	4512 - Father, Male, 34 Years	Burns / Scalding	Unfounded	

3051 - Deceased Child, Female, 1 Years	4511 - Mother, Female, 31 Years	Inadequate Guardianship	Unfounded
3051 - Deceased Child, Female, 1 Years	4513 - Other - Nurse, Female, 54 Years	Inadequate Guardianship	Indicated

Report Summary:
On 4/21/15, the SCR received a report stating that on 4/20/15, the SC was in the care of her LPN when she sustained 2nd degree burns on 45 % of her lower body. It was alleged that the LPN did not check the water temperature prior to putting the SC in the water. The SC was taken to the hospital where she was admitted for the burns. There were concerns about the parents' judgment in leaving the SC with the nurse. ACS investigation revealed that the parents did not reside in the home and were not present at the time of the incident. Additionally, ACS learned that the LPN said she had taken the child from the tub before adding hot water to the water that was already in the tub.

Determination: Indicated | **Date of Determination:** 06/19/2015

Basis for Determination:
ACS substantiated the allegations of IG and B/S against the LPN citing that she was responsible for the SC's burns which subsequently led to the SC's death.

ACS substantiated the allegation of IG against the BF citing that he had a suspended license and was driving his older child to school. ACS also mentioned the father's drug use, but did not specify how these issues were relevant to the SC. ACS unsubstantiated the allegation of Burns/Scalding as the SC was not in his care.

ACS unsubstantiated the allegations of Burns/Scalding and Inadequate Guardianship by the mother.

OCFS Review Results:
The SC received in-home nursing services. The assigned LPN submerged the SC in scalding water causing him 2nd and 3rd degree burns. The SC was admitted to the hospital where she died on 4/27/15. The LPN indicated that she checked the temperature of the water prior to placing the SC in the tub. However, the NYPD and medical staff found the LPN's account inconsistent with the SC's injuries. The SC died due to complications from the burns. The NYPD arrested the LPN and charged her with murder in the 2nd degree. The LPN remains incarcerated at Riker's Island. Bail was denied.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS' did not provide the basis to substantiate the allegation of IG against the BF for the SC. The narrative did not explain how the father's driving another child without a license, being involved with drug activity, or admission to smoking marijuana impacted his ability to provide a minimum degree of care for the SC. Based o the collaterals, there was no concerns about his care of the SC.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

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

Neither the family nor the nurse had any CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

Neither the family nor the nurse had a CPS history outside 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