NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-040 **Prepared by: New York City Regional Office**

Issue Date: 12/16/2015

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: 9 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 05/19/2015
Initial Date OCFS Notified: 05/19/2015

Presenting Information

On 5/19/15, the SCR registered a report alleging that the SC, who resided with her parents, PGM, PU, and paternal cousin (PC) was playing with the PGM. When the SC fell asleep, the PGM placed the SC on the bed while she went downstairs. Another adult household member found the SC unresponsive. The report stated there was no explanation for the SC's death. All the adults who resided in the home were present; therefore, they were all listed as subjects of this report. It was further noted that the SC's three-year-old PC resided in the home.

Executive Summary

The SC was 9 months old at the time of her death on 5/20/15. A verbal report from the ME stated that the cause of death was due to complications from the the child's pre-existing medical condition: hydrocephalus (excessive accumulation of fluid in the brain).

At 24 weeks gestation, the mother had an unassisted birth of the SC in the home; The SC weighed 1 pound and 3 ounces. Following the birth, the SC was then transported to Woodhull Hospital where she was diagnosed with hydrocephalus and chronic lung disease. The SC also suffered numerous medical complications and had five surgeries. She was transferred to several hospitals until she was discharged to the parents on 4/6/15. According to the medical staff from Bellevue Hospital where the SC continued treatment, the SC's life expectancy was low due to her medical issues.

On 5/19/15, the SCR registered a report with allegations of DOA/Fatality and Inadequate Guardianship of the SC by the parents, PGM and the PU. The parents resided with the PGM who had two adolescent children (SC's PUs) in the home. ACS observed these children and they were deemed safe in the care of the PGM.

The mother indicated that on 5/19/15, she fed the SC then burped her and held her for a while. She then placed the SC down on her back on the full size bed. The mother later went to change the SC's diaper and noticed the (SC) was not breathing; the SC's lips were purple and she was limp. The mother began performing CPR and called out for the father to assist. The father said that the mother then called 911 as he continued with CPR based on the instructions provided by the emergency medical operator. As the father continued with the CPR, milk and medicine came out of the SC's nose and mouth. The PU was in the kitchen when he heard the parents scream. He went to get the PGM who was on her way to the store. The PGM said she rushed back to the home and saw the father administering CPR to the SC.

According to the EMS liaison, the 911 call was received at 4:57 P.M. and EMS arrived at the scene at 5:04 P.M. EMS transported the SC to Woodhull Hospital where they arrived at 5:15 P.M.; the SC was pronounced dead at 5:20 P.M. The SC had no signs of abuse. Neither the NYPD, medical staff, nor the ME found the SC's death to be suspicious. The ME's preliminary report noted that the child died due to her medical condition.

The adolescent PUs had no first hand information as they were not present at the time of the incident. The adult PU's 3-year-old child who was mentioned in the SCR report did not reside in the home; however, ACS observed the child

who resided with his mother and he appeared well.

On 10/29/15, ACS unsubstantiated the allegations of the report concerning the parents and the PGM based on the ME's verbal report which noted that the SC likely passed away from complications due to her severe and chronic medical conditions; chronic lung decease, hydrocephalus, a shunt and premature birth. ACS also noted that numerous medical providers had no concerns about the care the SC was receiving. ACS determined that the PU was not a PLR as he had no childcare responsibilities for the SC; the allegations against the PU were unsubstantiated.

ACS has not received the autopsy report.

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

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: 05/19/2015 **Time of Death:** 05:20 PM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 04:57 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 001

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Male	14 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	13 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	47 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Other Child	No Role	Male	3 Year(s)

LDSS Response

Following the fatality report, ACS interviewed all the family members, service providers, medical staff, NYPD and ME. ACS also made contact with the schools that the surviving children attended.

The mother indicated that she fed the SC, burped her and held her for a while. She then placed the SC down on her left

side to sleep on the bed. The parents remained in the room with the SC as she slept. The mother said the father was playing a video game and she was sitting on the bed. The mother said she thought the child had defecated; therefore, she went to change the child's diaper. The mother said as she turned the child on her back she noticed the SC's lips were purple and the SC was not breathing. The mother said she began performing CPR and called out for the father to assist. The father said continued CPR based on the instructions that were being relayed to him by the mother who was receiving them from the emergency operator. The father said that as he was performing CPR, a mixture of milk and medicine was seeping from the SC's nose and mouth. The PGM indicated that prior to the incident she was on her way to the store when the adult PU came out of the case address screaming that there was something wrong with the SC. The PGM said she rushed back to the home and saw the father administering CPR to the SC.

According to the EMS report, the 911 call was received at 4:57 P.M. and EMS arrived at the scene at 5:04 P.M. EMS transported the SC to Woodhull Hospital where they arrived at 5:15 P.M. The SC was pronounced dead at 5:20 P.M. The SC had no signs of abuse. The NYPD indicated that they interviewed all family members and the SC's death did not appear to be suspicious. In addition, the medical staff and the ME concurred with the NYPD. The ME's preliminary report noted that the SC died due to medical complications from hydrocephalus.

The two adolescent PUs were outside playing when the SC was discovered unresponsive and had no first hand information of the incident. They arrived as the EMTs were rushing the SC into the ambulance.

ACS contacted the clinic where the SC had received routine care, and learned from the SW that the parents appeared very engaged with the SC. The SW indicated that the parents kept all medical appointments. The doctor's notes from the SC's medical chart also indicated positive observations between the parents and the SC. ACS learned that the SC's medical condition was very high risk and her life expectancy was determined to be low do to her existing medical issues.

ACS also interviewed the family members and none expressed concerns about the parents' ability to care for the SC. The parents had been linked with Prompt Care agency. The agency was scheduled to provide Early Intervention Services for the SC and assist the parents in applying for SSI. The parents had no income and were being supported by family members.

In June, as the investigation progressed, the family became unreceptive to ACS' ongoing contacts and did not accept bereavement services offered by ACS. However, the case documentation reflected that the ACS Specialists continued to make efforts to engage the family in services.

On 10/29/15, ACS unsubstantiated the allegations of the report concerning the parents and the PGM based on the ME's verbal report which noted that the SC likely passed away from complications due to her severe and chronic medical conditions; chronic lung decease, hydrocephalus, a shunt and premature birth. ACS also noted that numerous medical providers had no concerns about the care the SC was receiving. ACS determined that the PU was not a PLR as he had no childcare responsibilities for the SC; the allegations against the PU were unsubstantiated.

ACS has not received the autopsy report.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
017721 - Deceased Child, Female, 10 Mons	017722 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
017721 - Deceased Child, Female, 10 Mons	017722 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
017721 - Deceased Child, Female, 10 Mons	017723 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
017721 - Deceased Child, Female, 10 Mons	017723 - Father, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
017721 - Deceased Child, Female, 10 Mons	017724 - Aunt/Uncle, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated
017721 - Deceased Child, Female, 10 Mons	017724 - Aunt/Uncle, Male, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
017721 - Deceased Child, Female, 10 Mons	017725 - Grandparent, Female, 47 Year(s)	DOA / Fatality	Unsubstantiated
017721 - Deceased Child, Female, 10 Mons	017725 - Grandparent, Female, 47 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?	☒	☐	☐	☐
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:
N/A

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	☐	☐	☐	☐	☐	☒	☐
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 immediate needs in response to the fatality. The SC had no siblings; the PGM refused bereavement services offered for the minor PUs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs related to the fatality. Parents and PGM refused 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? N/A
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:

☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history within three years prior to the fatality.

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

The PGM was listed as a subject foster parent in an unfounded report dated 11/11/06 for allegations of IG of the now 13 and 14 year old PUs. The PGM was also listed as a subject in an unfounded report dated 10/4/10 for IG of the now 14 year old and the now adult PU. When the father of the SC was 18, he was also listed as a subject in this report for allegations of IG and SXAB of the now 13-year-old PU. The report was investigated and there was no credible evidence found to substantiate the allegations against him.

The mother was listed as a SC on a 4/6/06 report. The allegation of the report was IG; the MGM was the listed as the subject. At the end of the investigation the report was unfounded.

Known CPS History Outside of NYS

The family had no 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

The PGM was a kinship foster parent with Edwin Gould Services from 2/17/05 to 1/28/08. The home was closed voluntarily after she adopted the children in her care.

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

Action:	OCFS NYCRO is recommending a review of the Division of Child Protection's Child Safety Conference Policy, as it appears that conferences are not being held in a timely manner and are being held when there are no safety concerns for surviving siblings or children in the home.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No