NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-107 **Prepared by: New York City Regional Office**

Issue Date: 5/2/2016

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	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-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

Jurisdiction: Office Of Special Investigations

Date of Death: 07/12/2010

Age: 3 month(s)

Gender: Male

Initial Date OCFS Notified: 12/10/2015

Presenting Information

NYCRO did not receive official notification of this infant's death. NYCRO learned of the death during a case review involving a younger sibling. The case review revealed the parents took the 3-month-old infant to the hospital on 7/11/10. The infant remained in the hospital until the time of his death. He was pronounced dead by an attending physician on 7/12/10.

Executive Summary

This 3-month-old male infant died on 7/12/10. The ACS case record showed the infant was pronounced dead by the hospital attending Dr. who listed the manner of death as natural and the cause of death as a medical condition. NYCRO received documentation from the Office of Chief Medical Examiner in March 2016, indicating the infant's death was referred to the ME for cremation approval only. There was no autopsy performed and no autopsy report.

NYCRO became aware of this infant's death in December 2015 upon receipt of information regarding the death of a sibling (who died on 12/9/15). Regarding the infant who died on 7/12/10, ACS did not complete the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive cases. The information regarding this infant's death was not reported to OCFS under Chapter 485 of the Laws of 2006. ACS did not provide an explanation for the agency's failure to report the infant's death as required.

ACS case record reflected that the agency was in the process of investigating the 7/11/10 SCR report when the ACS staff learned of the infant's death. ACS included the information in the open CPS investigation case for further exploration. ACS found that the parents took this infant to the PGM's home on 7/6/10, in the evening, as part of a family bonding arrangement. According to the father's account, the family originally intended to allow the infant to remain in the PGM's care for only one day. The father said the parents changed the plans and infant temporarily resided with the PGM until 7/10/10. On 7/10/10 during the night, the parents retrieved the infant from the PGM's home and at that time they observed the infant seemed to have lost weight and he had other symptoms of illness. On 7/11/10, the parents took the infant to the hospital where he received medical treatment.

ACS staff observed the infant in the hospital and noted he was connected to machines for breathing and other treatment. The ACS staff and parents attended a meeting with the hospital medical staff on 7/12/10 where the hospital attending Dr. revealed that the infant had a serious medical condition. The Dr. explained there was no suspicion of abuse/maltreatment of the infant by the parents. Following this meeting, ACS learned the infant was pronounced dead on 7/12/10 at 11:30 p.m.

Following the infant's death, ACS obtained and reviewed medical records which showed the infant had was examined on 5/28/10 during a well-child visit. The infant had no observable marks/bruises and the Dr. had no reason to suspect abuse/maltreatment. This Dr. had been providing care of the infant since birth. The Dr. noted that the family was compliant with the infant's medical appointments and there were no concerns.

ACS staff visited the MGM's home, engaged household members and observed the sleeping arrangements were satisfactory. The MGM was the primary caretaker for the MU, who was then 9 years old. There were no other children in the household. The parents occupied a room in the MGM's home and had a portable crib for the infant. The parents said they had been in a relationship for about six years. The parents resided in Washington State from June 2009 through March 2010. ACS requested a child abuse register check from the Washington State Department of Children and Family agency. The results showed there were no results of child abuse/maltreatment cases or reports for the family.

Prior to closing the child protective case, ACS verified that the Mt. Sinai Hospital social work staff held bereavement counseling session with the family and had discussed referring the family to a Community Based Organization. ACS learned that the parents planned to relocate outside of New York State but had continued to reside in the MGM's home. However, ACS did not add the MGM and MU to the CONNECTIONS household composition.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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: 07/12/2010 **Time of Death:** 11:30 PM

County where fatality incident occurred: New York
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? 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? No
At time of incident supervisor was: Unknown if they were 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	8 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	3 Month(s)
Deceased Child's Household	Father	No Role	Male	18 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	56 Year(s)
Deceased Child's Household	Mother	No Role	Female	17 Year(s)

LDSS Response

ACS staff visited the MGM's home as required. The family had adequate provisions and the home conditions were satisfactory. ACS staff interviewed the parents about the infant's medical history. The mother said in May 2010, the infant appeared ill and she contacted his Dr. for assistance. She followed the Dr.'s directive and took the infant to the hospital Emergency Room (ER). Upon arrival in the ER, the infant's health improved and he did not receive medical treatment. The parents said the infant was not ill on 7/6/10. They explained that they left the infant in the PGM's care from 7/6/10 in the evening until 7/10/10. When they retrieved the infant they observed his ribs were prominent ribs and he had sunken cheeks. The infant had other symptoms of illness; therefore, they took him to the ER for medical evaluation on 7/11/10. The mother said during the ER visit, she observed the infant's health continued to deteriorate.

ACS staff visited the PGM's home and interviewed her regarding the case circumstances. The PGM said the infant appeared healthy at the time she returned him to the parent's care on 7/10/10. She said she learned about the infant's

illness after the parents took him to the ER on 7/11/10.

ACS learned there was LE involvement with the family. ACS noted that the LE said there were no suspicions regarding the infant's death. Also, the ACS staff contacted the District Attorney's (DA) office and was informed that the DA was not assigned to the infant's case.

According to the information provided to ACS by LE, it was alleged that the PGM had allowed another relative to supervise the infant for an undetermined period of time between 7/6/10 and 7/10/10 (the period during which the infant was in the PGM' care). ACS documentation showed on 7/11/10, the PGM went to the hospital where she had a physical altercation with the father. ACS staff interviewed LE who said there was an arrest of the PGM on 7/11/10 pertaining to the altercation with the father. Regarding this physical altercation, the ACS staff received a telephone call from the PGM's attorney who stated that the PGM must refrain from discussing her legal case with ACS staff unless the PGM's attorney was included in the interview.

During a 7/14/10 telephone interview with ACS staff, the hospital attending Dr. stated that the infant's death was unrelated to abuse/maltreatment. This physician added that the ME's office did not accept the case for an autopsy because the infant's death was due to natural causes. Subsequently, the Dr. provided documentation which stated that although the social circumstances were complex, the parents did recognize the infant's illness, they attempted to manage his illness at home, and when they failed, they sought medical attention for the infant. The Dr. explained that the feeding history in the PGM's home was unclear and it was unknown whether this aggravated the infant's presentation. The Dr. noted the underlying medical condition was believed to be at the root of the infant's illness and ultimate demise.

ACS staff met with the family in the ACS borough office on 7/21/10. During the meeting, the parents said they were awaiting official documents for cremating the infant's body. They said they planned to relocate out of New York State. Subsequently, during a telephone contact with the MGM, which occurred on 8/18/10, the ACS staff learned that the mother was in her eighth week of pregnancy. The MGM said the parents continued to reside with her but they were out of the home at the time of the telephone contact.

ACS reviewed records which showed the father, MGM and other relatives had individual history of domestic violence. The parents denied there were domestic violence incidents in their personal relationship. The ACS staff did not verify whether the family received domestic violence services.

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 reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
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 or 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?	☐	☒	☐	☐
Explain as necessary: N/A				

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: The parents received community based services.							

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 surviving children in the parents' care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
According to the 8/25/10 Investigation Progress Notes, the family had plans to obtain bereavement counseling through the hospital social worker.

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

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)
04/02/2009	8675 - Sibling, Male, 1 Years	8671 - Father, Male, 17 Years	Inadequate Guardianship	Unfounded	No

Report Summary:
The 4/2/09 SCR report alleged the father had a male child, who was then 9 months old. The report also alleged the father had anger management issues and he was referred to mental health evaluation. The father refused to follow through with the referrals. There was concern for the safety and well being of the child whose whereabouts were unknown. The father was non compliant with services and had refused access to the child.

Determination: Unfounded | **Date of Determination:** 06/01/2009

Basis for Determination:
ACS unsubstantiated the allegation of IG of the child by the father on the basis that the father cooperated with the investigation. ACS noted that the father disclosed this child's whereabouts. ACS found that the father was not the child's caretaker. This child resided with his mother and the MGM had filed for legal custody.

OCFS Review Results:
During a 4/2/09 interview with ACS staff, the father said he had pre-existing medical and mental health conditions. He said a couple of years prior to 4/2/09, he began to receive therapeutic services to address his behavior.

Regarding the allegations of the report, ACS verified the father had no child caring responsibilities. The ACS staff engaged and interviewed the child's mother and MGM and found there was a full stay away temporary order of protection dated 4/19/09, issued by Bronx County Family Court on behalf of the mother against the father: with exception for visitation agreements. This child's mother and MGM planned to file for full custody of the child.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/11/2010	8641 - Deceased Child, Male, 3 Months	8642 - Mother, Female, 17 Years	Inadequate Guardianship	Unfounded	No
	8641 - Deceased Child, Male, 3 Months	8642 - Mother, Female, 17 Years	Malnutrition / Failure to Thrive	Unfounded	

8641 - Deceased Child, Male, 3 Months	8643 - Father, Male, 18 Years	Inadequate Guardianship	Unfounded
8641 - Deceased Child, Male, 3 Months	8643 - Father, Male, 18 Years	Malnutrition / Failure to Thrive	Unfounded
8641 - Deceased Child, Male, 3 Months	8642 - Mother, Female, 17 Years	Inadequate Food / Clothing / Shelter	Unfounded
8641 - Deceased Child, Male, 3 Months	8643 - Father, Male, 18 Years	Inadequate Food / Clothing / Shelter	Unfounded

Report Summary:
The 7/11/10 SCR report alleged that the parents brought the 3-month-old child to the Emergency Room on 7/11/10, at noon because the child was ill since 7/10/10. The report also alleged the child was extremely malnourished. A few days prior to 7/11/10, the child weighed one pound more than he did on 7/11/10. The report stated that the parent's judgment was questionable.

Determination: Unfounded | **Date of Determination:** 09/02/1019

Basis for Determination:
ACS unsubstantiated the allegations of IF/CS, IG and M/FTTH of the infant by the parents on the basis that the parents observed the infant was ill and took him to the hospital where he was admitted. The infant remained in the hospital Pediatric Intensive Care Unit until he was pronounced dead. ACS noted that the agency received a letter from the hospital child protection team stating that the infant's death was due to underlying medical condition.

OCFS Review Results:
ACS staff interviewed the family members in the hospital on 7/12/10. The parents said between 7/6/10 and 7/10/10, they left the infant in the PGM's care for family bonding. After the infant returned to the parents, they observed he was ill and on 7/11/10 they took him to the hospital where he remained until he died. The hospital Dr. said the underlying medical condition was the cause of the infant's death.

The ACS staff assessed the infant received adequate medical care in the hospital. ACS visited the home and found the parents resided with the MGM and MU. ACS did not add the MGM and MU to the household composition. There was no new information about the half sibling.

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

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

The parents were not known as subjects of a report more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known 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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

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

Action:	NYCRO recommends that ACS evaluates its policies pertaining to the standards for recording and notification of fatalities, and assessment of surviving siblings.

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