Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-127

Prepared by: New York City Regional Office

Issue Date: Mar 25, 2020

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 12/14/2019
Initial Date OCFS Notified: 12/16/2019

Presenting Information

According to the narrative of the SCR registered on 12/16/19, the mother noticed the two-year-old child was not breathing on 12/14/19. The mother called EMS, who transported the child to Methodist Hospital, where the child was subsequently pronounced dead. No information was known regarding any medical issues the child may have had, or where she was found by the mother. No cause of death or time of death is known as of yet. It is unknown if there are other adults or children residing in the home. It is unknown if an autopsy will be completed or has been completed.

Executive Summary

The two-year-old female child died on 12/14/19. The ME has not provided a final autopsy report, but informed ACS the child's death may have been the result of a viral illness. The child resided with her parents; there were no other siblings or children in the household.

On 12/16/19, the SCR registered a report of the child's death with allegations of DOA/Fatality and Inadequate Guardianship of the child by the mother. There were no allegations against the father.

ACS's investigation revealed, on 12/11/19 the child had a fever with temperature of 101 degrees Fahrenheit. The parents kept the child home from school, administered Tylenol and encouraged water/fluids. During the night, the child's temperature spiked to 105 degrees and the parents brought her to Methodist Hospital. The child underwent medical testing and the results were negative for Influenza and Respiratory Syncytial Virus (RSV); her blood work was normal. The child was treated with Tylenol and some oxygen and discharged from the ER. The parents were directed to continue to provide medication for fever and to encourage fluids. On 12/13/19 , the child’s temperature was lower, and she appeared to be feeling better. However, at 9:00PM on 12/13/19 the child's temperature spiked to 101 degrees and they gave her Tylenol. The child was placed I her crib at about 10:00 PM and the father stayed with her in the room until she fell asleep. At about 3:00AM on 12/14/19, when the father heard the child coughing, he got up, took her out of her crib, and gave her some water in her sippy cup. The child went back to sleep in her crib. At 7:00AM when the father awoke, the child was sleeping; therefore, he went back to bed and woke up at noon. When the father attempted to wake the child he noticed the child's extremities were cold, but her abdomen was warm. She was not responding to their calls or touches. The parents called 911 and initiated CPR at the instructions from the operator until EMS arrived and the technicians continued resuscitative efforts. The child did not respond. The child was transported to the hospital in one ambulance while the parents were sent in another. The child was pronounced dead at the hospital at 1:24 PM on 12/4/19. Physicians at the hospital said there were no signs of trauma and it appeared the child's death was related to her recent illness.

ACS staff made contact with the appropriate collaterals including the child's pediatrician, the day care center the child had attended, law enforcement, and the ME. According to the ME stated there was no signs of trauma and death is related to a viral illness. Law enforcement indicated there did not appear to be any criminality associated with the death of the child. The day care provider indicated there were no concerns regarding the parents interaction with the child. The pediatrician reported the child's immunization was current and there were no concerns. The pediatrician also reported the child had been seen a few days prior to her death and was being treated for a cold.

ACS has not yet made a determination on this report, pending 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
The case documentation reflected timely initiation of the investigation. There was clear and concise notes documented. CPS made contact with the appropriate collaterals, and directives and guidance from the supervisor were adequate.

Was the decision to close the case appropriate? N/A
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:
ACS has not yet made a determination on the report.

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: 12/14/2019 **Time of Death:** 01:24 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 01:10 PM
Did EMS 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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 005 Hours
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 001
Adults: 000

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Father	No Role	Male	043 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	045 Year(s)

LDSS Response

Upon the receipt of the report on 12/16/19, ACS initiated the investigation in a timely manner by convening a Multidisciplinary Team (MDT) meeting and a Heightened Oversight Process (HOP) conference. The CPS staff and Investigative Consultant (IC) made a visit to the family's home. CPS conducted an assessment of the home and the functioning of the family. CPS documented there were no safety hazards and the parents had provided appropriate care for the child. CPS was able to establish contact with the family and the case documentation reflected good engagement of the family despite being emotionally distraught.

The family provided background information regarding the child's birth and provided a timeline of events that transpired from the time the child became ill on 12/11/19 until her death on 12/14/19. The parents, who were interviewed separately, stated that on 12/11/19 the child woke up with a fever. The child's temperature was monitored throughout the day and when it did not appear she was improving the child was taken to the hospital, treated and released. The parents reported the child’s breathing improved and she was discharged from the hospital on 12/12/19 at 12:00AM. The child was not discharged with medications, but they were told to give the child fluids and to monitor her temperature. The mother reported on 12/13/19 the child awakened lethargic but appeared better by the afternoon as she was smiling and dancing. BM says at about 9:00PM the child had a slight fever again and was sweating so she administered Tylenol to the child again. The mother said she too began to feel ill and chose not to be around the child; the father began caring for the child. The mother said on 12/14/19 at about noon the father went to check the child and she heard the father yell for her. The mother said the father grabbed his phone to call for emergency assistance and at that time she saw the child was lying on her back. The child's legs and arms were blue, and her body was stiff. The father began CPR and five minutes later the EMS technicians arrived and took over the resuscitative efforts. The child never regained consciousness. BM reported she and the father were escorted to the hospital via EMS but in a different ambulance.

On 12/16/19, the Specialist established contact with NYPD and learned no criminality was suspected. The detective reported an autopsy was completed on 12/15/19 at the ME’s office. There was no sign of criminality or homicide. Law enforcement conducted a home assessment and reported the home was appropriately furnished.

On the same date, CPS established contact with the neighbors who reported the family had been residing in the home for

over three years and there were no issues with the family.

On 12/16/19, 12/17/19, and 12/18/19, CPS contacted medical personnel and was informed the child was brought to the hospital on 12/14/2019 via EMS. The 911 call was made at 1:10PM. The parents reported the child was sick since 12/11/19, but appeared to be getting better. EMS performed CPR on the child however, the child was expired by the time they got to the hospital. Efforts were made by the team to resuscitate the child for over 10 minutes. The child never regained a pulse or heartbeat. The child was pronounced dead at 1:24PM. There were no signs of bruising, abuse, or neglect observed on the child. The child was also reported to be seen at the pediatric clinic associated with the hospital and was well cared for.

The Specialist established contact with the child's daycare on 12/17/19, and learned the child was enrolled in September 2019 part-time, and became a full-time student in October 2019. The mother was the person to drop-off and pick up the child and was reported to be kind a loving. The father was involved in the financial aspects of the child's enrollment and always notified the day care center of the child's illnesses.

On 12/18/19 contact was made with the ME who reported the child was observed to be free of any injuries. The ME further stated the cause of death may be a viral infection.

Also, on 12/18/19 the CPS contacted the DA's Office and was told the child's death was not being investigated as a criminal action.

ACS's case documentation reflected the Specialist maintained contact with the ME to obtain the cause and manner of death. To date, the ME has not provided final cause of death.

On 1/20/20, the family was provided with a list of bereavement counseling agencies after the parents declined ACS's referrals. The parens indicated they would seek services on their own after the child's funeral.

No safety assessment forms were required as the parents' only child had died and there were no other children in the home.

The investigation was ongoing at the time of the writing of this report.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: Case documentation reflected the involvement of a Multi-Disciplinary Team in this investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

053222 - Deceased Child, Female, 2 Yrs	053223 - Mother, Female, 045 Year(s)	DOA / Fatality	Pending
053222 - Deceased Child, Female, 2 Yrs	053223 - Mother, Female, 045 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The parents' only child died. ACS contacted law enforcement to ascertain this was the parents' only child.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral

Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents were offered bereavement counseling. No other concrete needs or services were identified.

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 are no surviving siblings or children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Parents were referred for bereavement counseling immediately following the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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

CPS - Investigative History Three Years Prior to the Fatality

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

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

The family had no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family had no known CPS history outside of NYS.

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