NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-16-014 **Prepared by: Spring Valley Regional Office**

Issue Date: 10/4/2016

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
FM-Foster Mother	SS-Surviving Sibling	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 05/05/2016
Initial Date OCFS Notified: 05/05/2016

Presenting Information

On 5/5/2016, a case was called in to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR), which alleged DOA/Fatality and Inadequate Guardianship regarding the mother and father on behalf of the 2-year-old male subject child. This report alleged the subject child died in his home while in the parents care, with no other known pre-existing health conditions, excluding allergies.

Executive Summary

The investigation revealed that on the morning of 5/4/2016, the subject child had a temperature of 99 F degrees, and was acting and eating normally. The subject child was taken to his usual day care, where staff were alerted that he had a temperature, and asked to keep a close eye on him. At 2:00 PM, the father contacted the day care and was told the subject child was asleep and felt warm to the touch, but didn't feel warm when they put him down. At 3:00 PM, the father was contacted by the day care and informed the subject child had a temperature of 103 F degrees. The father contacted the mother who arrived at the day care to pick-up the subject child approximately 10 minutes later. At home, the mother checked the subject child's temperature and it was 100 F degrees. The mother was able to video-chat for medical advice and recommendations, with the paternal aunt, a Nurse Practitioner, and the subject child appeared to be acting normal at that time. The mother put the subject child to bed, on his back in his crib, at approximately 9:00 PM. At approximately 10:30 PM, the mother stated that she watched the subject child on the baby monitor adjust himself to a comfortable position. At approximately 4:45 AM on 5/5/2016, the father observed the subject child asleeping in his crib with his knees tucked under his stomach and his buttocks in the air, on the monitor. At 5:30 AM, the father checked the monitor and observed the subject child in the same position. He then went to check on the subject child in his crib and found the subject child's feet to be cool to the touch. The father was also unable to wake the subject child by rubbing his back or turning his head. The father then alerted the mother who also went to check on the subject child and found him to be unresponsive. The mother called 911 and the father began chest compressions. Approximately five minutes after contacting 911, EMS arrived and attempted CPR. EMS noted the subject child's jaw was tight and his hands showed early signs of rigor mortis indicating he had been deceased since approximately 2:00 AM or 3:00 AM. A paramedic called the time of death of the subject child at 5:55AM. It was noted the mother alternated in administering over the counter children's Motrin and Tylenol to the subject child throughout the 72 hours prior to his death as he was running a fever.

An autopsy was performed on the subject child on 5/5/2016. No outward or visible signs of abuse and/or neglect were observed on the subject child and the final results of the autopsy were not yet completed as the toxicology report was pending. Contact with local law enforcement officials indicated there was no criminal charges filed, no negligence, and no signs of trauma. The detective on the case indicated the subject child appeared well cared for and although still waiting on the final autopsy report, he was made aware by the Medical Examiner that the possible cause of death was a possible genetic disorder. The final autopsy report was not yet received at the time of case closure. A Law Enforcement Summary was received by OCFS on 8/11/16 listing the manner of death as natural and the cause of death as Sudden Unexpected Death of a 2-year-old child with recent adenovirus infection and cerebral edema.

Contact with the pediatrician and day care provider indicated no suspicion or concern for the family or well being of the subject child. Both spoke highly of the family. The subject child was up to date on immunizations and all appointments were kept. The day care also stated that the subject child was well cared for.

The CPS investigation was closed on 7/1/2016. All of the allegations listed on the report were unsubstantiated regarding the mother and father on behalf of the subject child. Appropriate service referrals were offered to the family however; they were declined as the parents were reportedly receiving services privately.

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:
Sufficient information was gathered to determine the allegations listed on the report, and all assessments were appropriate.

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:
The level of casework activity throughout the investigation was appropriate.

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: 05/05/2016 **Time of Death:** 05:55 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: WESTCHESTER
Was 911 or local emergency number called? Yes
Time of Call: 05:46 AM
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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 7 Hours
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: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

Westchester County Department of Social Services, (WCDSS), conducted an investigation into the allegations listed on the report. WCDSS made many appropriate collateral contacts including the Medical Examiner, local law enforcement officials, medical professionals, relatives, and community resources. All subjects were interviewed and observed, and the allegations were discussed. Appropriate service referrals were offered to the family.

There were no surviving siblings or other minor children residing in the home at the time of the fatality, or during the investigation. WCDSS completed all safety assessments and the risk assessment profile (RAP) accordingly. The case notes were well documented, detailed, and contemporaneous.

As per the Medical Examiner's office, an autopsy was performed on the subject child on 5/5/2016. The Medical Examiner noted no indication of any trauma or other injury indicative of abuse or neglect. At the time this report was completed the final autopsy results were pending and the final toxicology reports were not yet received. Local law enforcement officials

also reported not noting anything suspicious surrounding the subject child's death, and explained that there might have been underlying health issues. A Law Enforcement Summary was received by OCFS on 8/11/2016. The final autopsy results listed the cause of death as Sudden Unexpected Death of a 2-year-old child with recent adenovirus infection and cerebral edema. The manner of death was listed as natural.

There was documentation of supervisory conferences noted in which the circumstances of the case were discussed and directives were provided.

The CPS investigation was closed on 7/1/2016 and the allegations on the report were unsubstantiated regarding the mother and father, on behalf of the subject child for Inadequate Guardianship, and DOA/Fatality. There were no concerns noted by the subject child's Pediatrician or day care provider and no trauma or other injury indicative of abuse and/or neglect during the autopsy. No evidence was found to suggest that the parents were responsible for the subject child's death. Appropriate service referrals were provided to the family. However, the family said that they sought services, and the services were helping them cope with the loss of their son.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: The fatality investigation was conducted by an MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: An OCFS approved Child Fatality Review Team meeting was held on 5/16/2016 to discuss this case.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
029881 - Deceased Child, Male, 2 Yrs	029882 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
029881 - Deceased Child, Male, 2 Yrs	029883 - Father, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated
029881 - Deceased Child, Male, 2 Yrs	029883 - Father, Male, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
029881 - Deceased Child, Male, 2 Yrs	029882 - Mother, Female, 33 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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
Attempted contact was made by WCDSS to speak with the babysitter with no response.

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	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:
Victims Assistance Services were offered to the family however they were declined as the family reportedly was receiving 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 siblings or other minor children residing in the household at the time of the fatality or throughout the investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Victims Assistance Services were offered to the family, and declined.

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

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

There is no known history on file for the family.

Known CPS History Outside of NYS

There is no known history outside of New York State.

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.

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