NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-062 **Prepared by: New York City Regional Office**

Issue Date: 12/9/2016

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: 3 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 06/24/2016
Initial Date OCFS Notified: 06/24/2016

Presenting Information

On 6/24/16, the SCR registered a report regarding the death of the three-month-old female subject child (SC). The report alleged sometime in the morning of 6/24/16, the SC was found deceased by her parents in her playpen. There was no explanation for the SC's death. The SC did not have any known medical condition and was considered an otherwise healthy child. According to report, the parents were being considered responsible for the SC and therefore considered alleged subjects.

Executive Summary

This three-month-old female SC died on 6/24/16 while in the care of her parents. According to ACS' investigation, at 7:00 A.M., the BM found the SC unresponsive and blue in the playpen she shared with her twin sister. The BM immediately yelled out for help and the paternal uncle (PU) called 911. The 911 operator instructed the PU to give the SC CPR until EMT's arrival. Approximately five minutes later, EMT arrived at the home and took over resuscitation efforts on the SC. EMT then transported the SC to the hospital where medical staff pronounced her dead. According to the ME, the SC's cause of death was undetermined. The manner of death was natural.

The SC and her twin sister were born at thirty one weeks gestation with a breathing condition. Following their birth, the twins spent five weeks in intensive care and were discharged with pediatric visiting doctor's program and visiting nurse services (VNS).

On 6/24/16, the ACS Specialist initiated the investigation and conducted initial interviews and assessments of the family and the surviving siblings. The statements obtained from the family and the information provided by other relevant collaterals regarding the fatality were consistent. There were no safety concerns for the surviving siblings.

On 7/19/16, ACS held a family team meeting (FTM) with the family to reduce the risk of future harm to the surviving children. The FTM recommended a service plan with the family which included PPRS services and referral for grief counseling. The family declined services and stated they received support from family members; however, they accepted referral for daycare services for the surviving children.

At the time of writing this report on 12/7/16, ACS had not made a determination of the report. The three surviving children remained with the parents and there were no concerns regarding their care. The VNS, the pediatrician and the hospital social worker continued weekly visits to the home to assess the surviving siblings.

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?** N/A

- **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?** 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:
At the time of writing this report, ACS had not made a determination of the report.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
At the time of writing this report, ACS had not made a determination of the report.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Progress Notes
Summary:	Between 9/21/16 and 10/21/16, the Specialist did not document case related activities although there were supervisory directives dated 9/14/16 and 10/2/16 to do so.
Legal Reference:	18 NYCRR 428.5
Action:	The Administration for Children's Services must submit a corrective action plan within 45 days that identifies what action it has, or will take to address the citation identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	On 9/21/16, the Specialist visited the family but failed to assess the surviving children's safety. Also, the Specialist failed to ask the family how the SC and her sister were placed to sleep and the SC's position when she was found unresponsive.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	The Administration for Children's Services must submit a corrective action plan within 45 days that identifies what action it has, or will take to address the citation identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:	Adequacy of case recording
Summary:	Although the case records reflect a toddler bed and a crib were ordered for the family, there was no documentation to indicate they were provided to the family.
Legal Reference:	18 NYCRR 428.5(c)
Action:	The Administration for Children's Services must submit a corrective action plan within 45 days that identifies what action it has, or will take to address the citation identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:	Diligence of Efforts
Summary:	The Specialist did not make further diligent efforts to contact the children's pediatrician and inquire about any concerns regarding the children's health and overall medical care.
Legal Reference:	NYCRR 430.12D
Action:	The Administration for Children's Services must submit a corrective action plan within 45 days that identifies what action it has, or will take to address the citation identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/24/2016 **Time of Death:** PM

Time of fatal incident, if different than time of death: 07:00 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 07:11 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
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	Aunt/Uncle	No Role	Male	20 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	22 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	16 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	18 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	54 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Month(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 6/24/16, the ACS Specialist initiated the investigation and contacted the assigned detective and EMS. The detective reported that the family members provided similar accounts of the incident; which revealed that at approximately 7:00 A.M. on 6/24/16, the BM found the SC unresponsive and blue in the playpen she shared with her twin sister. The detective stated that preliminary findings did not indicate any foul play and there would be no arrest.

Following the contact with the detective, the Specialist visited the case address to assess the family and the surviving siblings. The statements provided by the family were consistent with the time line surrounding the SC's death. The Specialist did not document any concerns for the surviving siblings.

On 6/28/16, the EMS liaison provided a consistent time frame of EMS' engagement with the family.

On 7/11/16, the Specialist visited the family. The family did not provide any new information about the SC's death. The Specialist observed the surviving children to be safe in the home.

On 7/19/16, ACS held a family team meeting (FTM) with the family to reduce the risk of future harm to the surviving children. The FTM recommended a service plan with the family which included PPRS services and referral for grief counseling. The family declined PPRS and grief counseling services stating they received support from family members; however, they accepted referral for daycare services for the surviving children.

On 7/29/16, the Specialist made a follow-up visit to the case address. The family expressed their frustration at the Specialist's continued visits to the home; however, the PGM requested ACS' assistance for a toddler bed and a crib for the surviving children. The Specialist observed the surviving children to be free of marks and bruises. There were no reported concerns for the children.

On 7/12/16 and 8/1/16, the Specialist requested via facsimile the surviving children's medical records. Although the BM signed the HIPPA forms for the children, the Specialist did not make further diligent efforts to contact the children's Dr. and inquire about any concerns regarding the children's health.

On 8/1/16, ACS held a child safety conference (CSC) in respect of the family. The family did not attend or participate in the CSC. Due to the family receiving pediatric visiting doctor and VNS services for the surviving children, the CSC did not recommend court intervention for the family.

On 8/17/16, ACS held a follow up CSC to review the family's safety plan. According to the case notes, the VNS and the Dr. continued weekly visits to the family, but the family had not engaged in PPRS services.

On 9/14/16, the Specialist visited the family and the BM reported that her hospital SW gave her a referral for clinical health services. She promised to follow-up with the SW for an intake appointment. The Specialist observed the surviving children to be safe in the home at the time of the visit.

On 9/21/16, the Specialist visited case address and provided the family with relevant documentation to support the family's application for Public Assistance. The case records did not reflect the Specialist assessed the surviving children's safety during this visit.

On 10/21/16, the Specialist visited the case address to provide the family with information regarding alternative education. There were no concerns observed for the surviving children during the visit.

On 11/22/16, ACS obtained notification from the ME which indicated the SC's cause of death was undetermined. The manner of death was natural.

At the time of writing this report on 12/7/16, ACS had not made a determination of the report. The three surviving children remained with the parents and there were no concerns regarding their care. ACS documented the VNS, the pediatrician and the hospital social worker continued weekly visits to the home to assess the surviving siblings.

Official Manner and Cause of Death

Official Manner: Natural
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)?No
Comments: The investigation adhered to approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
029381 - Deceased Child, Female, 3 Mons	032130 - Father, Male, 18 Year(s)	Inadequate Guardianship	Pending
029381 - Deceased Child, Female, 3 Mons	032129 - Mother, Female, 19 Year(s)	DOA / Fatality	Pending
029381 - Deceased Child, Female, 3 Mons	032130 - Father, Male, 18 Year(s)	DOA / Fatality	Pending
029381 - Deceased Child, Female, 3 Mons	032129 - Mother, Female, 19 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:

The Specialist failed to enter progress notes in a timely manner. Between 9/21/16 and 10/21/16, the Specialist did not document case related activities although there were supervisory directives dated 9/14/16 and 10/2/16 to do so.

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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?	No
Was the child acutely ill during the two weeks before death?	No

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

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 did not have any prior history.

Known CPS History Outside of NYS

The family did not have any known CPS 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

The family was in receipt pediatric visiting doctor's program and visiting nurse services 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