Child Fatality Report

Report Identification Number: NY-17-125

Prepared by: New York City Regional Office

Issue Date: May 07, 2018

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		

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 11/03/2017
Initial Date OCFS Notified: 11/06/2017

Presenting Information

On 11/6/17, two reports were registered with the SCR alleging the SC had severe allergies involving dairy foods and was given a cheese sandwich at the daycare which allegedly caused him to be sick. The reports alleged the incident occurred on 11/3/17 at the day care, and the child died after eating the sandwich. The report alleged when the child began to exhibit signs of respiratory distress, no one called for emergency medical attention.

The subsequent report alleged the mother was aware the SC had ingested a cheese sandwich which caused him to experience an allergic reaction, but did not immediately seek medical attention. The report noted the SC began to have hives and then had difficulty breathing.

The allegations of the reports were DOA/FATL, LMC and IG.

Executive Summary

The SC was three years old when he died on 11/3/17. As of 4/23/18, the ME had not issued the autopsy report or provided a preliminary cause and manner of death.

On 11/6/17, the SCR registered two reports concerning the SC's death. The reports listed the directors of the daycare and the education, head teacher, a special education iterant teacher (SEIT), a volunteer, and the mother as the subjects. The allegations of the reports were DOA/FATL, LMC and IG.

ACS' Office of Special Investigations (OSI) and the Manhattan Field Office (MFO) staff who were assigned to investigate the reports collaborated to initiate the investigations within the required timeframe. All subjects of the reports were interviewed.

On 11/6/17, ACS made the initial home visit and assessed the home was appropriate. The were no safety concerns regarding the sibling.

The case documentation reflected that on 11/3/17, the SC urinated on himself while at the daycare and the mother was called to bring a change of clothes. The mother noticed the SC had "red marks" on his body so she administered Benadryl. The mother was called a second time because the SC again urinated on himself and was wheezing. The mother brought another change of clothes, and gave the SC a treatment with his nebulizer. The mother left the day care with the SC at an unspecified time and took him to Harlem Hospital where he was pronounced dead at 2:49 P.M.

At the beginning of the investigations, ACS attempted to interview the medical staff at the ER, but they refused. The documentation does not state whether ACS continued efforts to interview the staff after the parents signed the HIPAA.

The SEIT indicated she had informed the teacher the SC had taken two bites of a grilled sandwich, but the teacher denied the SEIT's account. Therefore, this information was not initially shared with the mother. Throughout the investigations, there was no clear timeframe for the events leading up to the SC's death.

The parents indicated they submitted all the relevant documentation concerning the SC's medical issues prior to the SC's enrollment. ACS confirmed this information and there was no documentation the mother was immediately advised the SC

had eaten cheese.

On 11/8/17, the surviving sibling was interviewed at the Child Advocacy Center (CAC) and there was no indication of abuse or maltreatment. ACS made collateral contacts concerning the sibling and had no concerns about the parents' ability to care for him.

ACS learned the daycare was closed by the Department of Health (DOH) on 11/9/17.

On 12/7/17, OSI substantiated the allegations of DOA/FATL, LMC and IG of the SC against the directors of the daycare and the head teacher. ACS cited they failed to call 911 and did not attempt to administer CPR. ACS also cited they were trained to handle a child in crisis and did not follow their training or the daycare's procedures.

ACS unsubstantiated the allegations of LMC and IG of the SC by the SEIT because "she was not a daycare staff," and unsubstantiated the allegation of IG of the fifth subject based on the fact that she was a volunteer.

Two weeks later, on 12/22/17, ACS ammended the initial decision and unsubstantiated the allegation determination for the DOA/FATL based on not having the "cause and manner of death". This was not appropriate casework practice. The initial decision provided narratives that properly supported the substantiation of the DOA/FATL and was consistent with the standard of "some credible evidence" and the legal definition-maltreatment.

As of 4/23/17, the MFO has not made a determination for the familial 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?** 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?** Yes

Explain:
The MFO had not made a determination therefore, no safety assessment had been completed as of 3/30/18.

Was the decision to close the case appropriate? Unknown

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	Unable to Determine
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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The MFO's documentation of supervisory notes were not clear and concise and did not focus on the SC. In addition, the supervisory directives were entered 30 to 60 days late. This did not demonstrate appropriate guidance for the Specialist.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The MFO's investigation was overdue and yet by 3/30/18 they had not documented any relevant collateral contacts concerning the mother who was the subject of their report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	OSI's CPS team made an appropriate determination concerning the DOA/FATL allegation and provided a strong narrative to support their decision. However, administrative staff changed this decision.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The 30-day safety assessment was not completed by the MFO at the time that OSI completed the 30 Day report.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/03/2017 **Time of Death:** 02:49 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? No
Did EMS 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? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Father	No Role	Male	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

During the month of November 2017, ACS interviewed the subjects of the reports.

The mother said on 11/3/17 she dropped the SC off at the day care by 9:00 A.M. The mother said she received a call from the day care informing her the SC needed a change of clothes. The mother went to the day care and noticed the SC was breaking out in hives; and she gave him Benadryl. The mother returned home and received a second call informing her the SC was wheezing. She returned to the day care with the SC's nebulizer and administered a treatment. The mother decided to take the SC home, but he did not "appear like himself." Therefore, she took him to the ER where efforts to resuscitate him failed.

ACS assessed the parents to be knowledgeable of the SC's medical issues and were able to explain the symptoms of the

SC medical conditions; and use of the medications and equipment.

From 11/3/17 through 11/9/17, ACS interviewed the day care staff. However, the time line of events was estimated by each staff.

According to the SC's teacher, on 11/2/17 the SC was breathing heavy so she did not take him to the park with the other children. The teacher said the mother was noticeably upset and insisted the SC was fine. The teacher reported on 11/3/17 the SC played with the other children and at about 12:15 P.M. they had lunch. The SC's lunch consisted of cucumbers, tomatoes, beans, bread and soy milk. The teacher said she later noticed there was a cheese sandwich in the SC's area but was unsure whether he had eaten any of it. She said the SC began to cry and urinated on himself; but he did not have a full change of clothes. The teacher said the SC had two "small bumps" near his mouth. The mother was contacted and arrived at the day care with a change of clothes. The teacher left the day care from 1:45 P.M. to 2:45 P.M.; and when she returned, she observed the mother was at the day care administering a nebulizer treatment to the SC who did not return to the classroom.

According to the SEIT teacher, the SC's class returned from the park to the day care for lunch at 12:00 P.M. The SC was served a meal according to his diet. However, when she returned from washing her hands, there was a cheese sandwich in the SC's hands and he had taken a bite. The SEIT said she threw out the sandwich, and informed the teacher. She did not know whether the SC was given two meals or if he took another's child's lunch. The SEIT stated the SC urinated on himself and the teacher escorted him to the bathroom. The teacher then asked her to get the SC's change of clothes but there were no socks or underwear. The SEIT said she left the day care at 12:35 P.M. and the mother had not yet arrived.

The day care's family assistant (FA) stated that on 11/3/17, the SC was dropped off at the day care at about 8:00 A.M. by the mother. At about 12:20 P.M. she was told the SC needed a change of clothes. The FA said she contacted the mother who arrived at the day care at about 12:30 P.M. with the change of clothes and gave the SC Benadryl. She said the mother left the day care at about 1:05 P.M. At about 1:20 P.M. she was asked to call the mother because the SC was wheezing. She stated the mother returned to the day care at about 1:30 P.M. The FA said the mother gave the SC a nebulizer treatment and left with the SC at 1:50 P.M.

The day care director was working at another site at the time of the incident and was informed of the events by the staff on site.

The SC's medical records noted that on 11/03/17 at 2:01 P.M., the SC was brought to the ER by the mother. The SC was crying, talking, and fussing when he arrived at the ER. The record noted efforts to attend to the SC began upon arrival to the ER to no avail; and he was pronounced dead.

The NYPD stated there were no contents of dairy found on the top part of the SC's stomach; and further examination was pending. There was no trauma to the SC's body.

The ACS MFO's report determination is pending.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

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
042066 - Deceased Child, Male, 3 Year(s)	042067 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Pending
042066 - Deceased Child, Male, 3 Year(s)	042067 - Mother, Female, 30 Year(s)	Lack of Medical Care	Pending
042066 - Deceased Child, Male, 3 Year(s)	042067 - Mother, Female, 30 Year(s)	DOA / Fatality	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	☐	☒	☐	☐
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:
ACS was in contact with the NYPD. The NYPD had no suspicions concerning the circumstances surrounding the SC's death on 11/3/17. As of 3/31/18, ACS has not interviewed the hospital staff.

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?	☐	☐	☒	☐
Explain: The 30- day safety assessment was not completed.				

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	☒	☐	☐	☐
Explain: The determination for the MFO investigation is pending.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
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	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	☐	☐	☐	☐	☐	☒	☐

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? Yes
Explain:
The sibling was referred for bereavement services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? Yes
Explain:
The parents/caretakers were referred for PPRS and bereavement 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?	No
Was the child acutely ill during the two weeks before death?	No

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

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

Known CPS History Outside of NYS

The family had no known history outside 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