Child Fatality Report

Report Identification Number: NY-19-064

Prepared by: New York City Regional Office

Issue Date: Dec 03, 2019

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: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 06/10/2019
Initial Date OCFS Notified: 06/10/2019

Presenting Information

The 6/10/19 report alleged the eight-week-old male SC stopped breathing. The BM contacted emergency services and the SC was taken to a hospital where he was pronounced dead. The SC was an otherwise healthy child.

Executive Summary

This 2-month-old male SC died on 6/10/19. NYCRO had not yet received the ME's report at the time this fatality report was issued.

On 6/10/19, the SCR registered a report that included the allegations of DOA/Fatality and IG of the SC by the SM.

ACS investigated the report and found the SC was ill two weeks prior 6/10/19; therefore, the SM took him to the physician and the local hospital between 6/3/19 and 6/9/19. The SC was discharged as stable from the hospital to the SM on 6/9/19. He was scheduled for a follow up evaluation with his physician on 6/11/19. However, on 6/10/19, the SM observed he was ill, and she contacted the physician at approximately 12:00 PM to reschedule to 6/10/19. She attempted to feed the SC at approximately 2:20 PM, and when he did not accept the bottle, she decided to call a taxi to transport them to the hospital. However, the SM's friend was at home, and she contacted 911 for assistance. At 2:53 PM, LE responded to the home and performed CPR while transporting the SC to the local hospital. The SC and LE arrived at the hospital at 3:04 PM. The SC was intubated, and chest compressions were conducted until he was pronounced dead at 3:29 PM.

During the investigation, ACS visited the hospital and interviewed medical staff. ACS obtained information regarding the SC's medical history. ACS learned that the SC seemed healthy with no medical concerns, and no visible signs of abuse or trauma on the body.

ACS visited the home and interviewed the SC's MGM, and SM's friend who resided in the same apartment. The results of the interview showed the SM resided in a room which included a queen-sized bed, crib, bassinet, rocking chair and play pen. The MGM and BF were resource relatives for the SM and SC. ACS observed the home conditions and found the sleeping arrangements were satisfactory. There were no hazardous conditions in the home and ACS observed protective devices (smoke and carbon detector). ACS observed the friend's 2-year-old female child in her MGM's home. This 2-year-old child did not have suspicious marks or bruises.

The SM's friend provided an account of her activities and the information appeared consistent with the details previously documented in the ACS case record. According to the friend's account, she observed the SC was in distress as he seemed blue, and she contacted 911 for assistance. The SM planned to call for a taxi to transport the SC to the hospital; however, the friend reported advising the SM that 911 must be notified. The friend did not have concerns about the care the SM provided the SC.

During an interview with ACS, the MGM said the SM called and informed her of the SC's medical emergency. The MGM said she went to the hospital where she was informed of the SC's death. ACS met with the BF who reported learning of the SC's death from the SM. The BF said that the last time he saw the SC he appeared happy and smiled often. ACS offered the BF bereavement counseling; however, he declined. The MGM and BF did not have concerns about the care the SM provided the SC.

On 08/09/19, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SM. ACS referenced the findings of the SC's medical records and physician's account which supported the SM's account of taking the SC for his medical evaluations, prior to his hospitalization. The SC's physician revealed there were no concerns of abuse/maltreatment of the SC.

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?** 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 all allegations.

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:
ACS obtained relevant information from the collateral contacts. There was no safety assessment due at the time of determination as there were no surviving siblings or other children in the BM's care.

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: 06/10/2019 **Time of Death:** 03:29 PM

Time of fatal incident, if different than time of death: 02:49 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 02:49 PM
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
At time of incident supervisor was: Not 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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)

LDSS Response

ACS Emergency Children Services (ECS) initiated the investigation on 6/10/19 and learned that the SC was ill and admitted to the local hospital four days prior to 6/10/19. ACS learned that the SM was instructed by medical professionals to follow-up on 6/11/19 to obtain medical examination with the SC's physician.

On 6/10/19, ACS contacted the CAC and obtained information about LE's investigation. According to LE's account, at the time police responded, EMS was not on the scene at the case address. LE noted that the SC seemed blue in the face and was ill. The SC was immediately transported by LE to the local medical center.

ACS interviewed an attending physician and learned that the SC was given medications and chest compressions because he arrived at the hospital with no heart rate. The course of treatment was unsuccessful; therefore, the SC was declared dead. The medical team observed the SC's body and found he did not have suspicious marks/bruises, and there was no evidence of abuse/ma/treatment. ACS verified the SC was discharged from the local hospital on 6/9/19. At the time of discharge, the hospital instructed the SM to continue to feed the SC.

On 6/10/19, the SM reported that the SC was admitted to the hospital approximately one week prior to 6/10/19. The SM said that on 6/10/19 she breast fed the SC at regular periods of time between 7:10 AM and 1:00 PM, and at 1:45 PM she changed his diaper. Subsequently, ACS learned that the SM gave the SC Pedialyte at 10:00 AM, and 12:00 PM. The documentation showed the SM attempted to feed the SC at 2:20 PM but he refused to accept the bottle. The SM's friend called 911 and LE escorted the SC to the local hospital. The SM denied she misused alcohol or other substances. ACS verified there were no surviving children in the SM's care.

On 6/10/19 and 6/13/19, ACS initiated the Heightened Oversight Protocol (HOP) and conducted a HOP conference. During the conference, ACS reviewed the preliminary findings of the investigation and case circumstances. ACS met with the investigative consultants and completed the investigative clearances. The clearances showed the SM had no criminal history.

On 6/11/19, ACS met with the clinical consultation team to discuss the case and devise a plan to assist the SM. ACS also held a family team conference and referred the SM to individual therapy and bereavement counseling. The medical consultant recommended that ACS obtain the SC's medical records. Between 6/12/19 and 6/13/9, ACS had medical, mental health, and early childhood consultations, and requested the SC's medical records.

On 6/18/19, ACS contacted the SM and learned that the SC's funeral was held on said date. ACS offered the SM burial assistance.

On 7/3/19, ACS contacted the ME's office and learned that the autopsy of the SC was performed on 6/11/19, and the results were pending. ACS interviewed LE and verified the criminal case was closed pending the SC's toxicology results.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051966 - Deceased Child, Male, 2 Mons	052288 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
051966 - Deceased Child, Male, 2 Mons	052288 - Mother, Female, 39 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

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 SM was referred to 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 SSs in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM was referred to individual and bereavement counseling.

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

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

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

Known CPS History Outside of NYS

There was 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

Additional Local District Comments

There are no additional Local district comments.

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