NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-021 **Prepared by: New York City Regional Office**

Issue Date: 8/23/2016

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
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		

Case Information

Report Type: Child Deceased
Age: 10 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 02/24/2016
Initial Date OCFS Notified: 02/24/2016

Presenting Information

The 2/24/16 SCR report alleged at approximately 1:59 AM the police and emergency medical services were called to the home of the mother and father for an unresponsive 10-year-old child. The child was sick for two days with a fever. The parents gave the child medicine but did not seek medical services for the child. The child had no known pre-existing medical conditions. The parents called 911. When EMS arrived at the home they found the child face up on the living room floor unconscious and not breathing. EMS performed CPR and continued until the child reached the hospital. The child was pronounced dead by authorities at approximately 2:04 AM. The cause of death was unknown.

Executive Summary

This 10-year-old male child died on 2/24/16. As of 8/22/16, ACS has not yet received a copy of the ME's final report. The ME provided preliminary findings to ACS. The ME stated the child had no internal injuries, no suspicious markings or trauma to the body. The official cause and manner of death was pending the results of additional tests.

The allegations of the 2/24/16 SCR report were DOA/Fatality IG, and LMC of the child by the parents.

The child became ill on 2/21/16 with a cold. That night, the family ate a seafood dinner and complained of stomach pain and diarrhea; the father also reported feeling ill. The parents observed the child continued to exhibit signs of malaise. The child refused to eat but was given hydrating liquids. On 2/23/16, the child exhibited symptoms of illness. The mother denied the child had a fever. The father purchased a liquid over-the counter children’s medication from the pharmacy around 4:00 PM. With the provided measuring cup, the mother gave a full dose of medicine to the child at approximately 5:00 PM, a second dose around 8:00 PM and a third dose at approximately 10:45 PM. Later on, the mother observed the child became incoherent and began to breathe rapidly. The parents called for a taxi; however, the mother observed the child’s respirations became shallow and she called 911 the morning of 2/24/16. The parents received instruction and provided CPR to the child.

Upon EMS’ arrival, the child was in the supine position on the floor. Emergency medication was administered and CPR was continued and the child remained unresponsive. The EMS carried the child on a stretcher down five flights of stairs and transported the mother and child in the ambulance to St. Luke’s Hospital. The hospital ER staff continued resuscitation efforts until the child was pronounced deceased.

The family temporarily resided in the deceased MGM’s one bedroom apartment of a five story walkup. Prior to the child’s death, the parents tried to acquire the apartment; however, housing court ruled against the parents. The apartment appeared old and dark with the smell of urine. The Specialist observed two dogs in a cage in the living room. The living room had separate beds for the parents and child. Despite the clutter, smell, unclean walls and old flooring, the apartment was not unkempt. The cabinets contained canned foods, dry soup and barely food in the refrigerator and freezer. ACS documented that there were concerns about the general condition of the home although there were no surviving children in the parent's household.

According to ACS, the family lived a reclusive lifestyle from the community. The child had not been visible to the

school or medical community in three years. The child had no preexisting medical conditions. There was no medical documentation of the child's weight at the time of death. The child attended an Online School since kindergarten that was approved by their state of residency. It was unknown whether the school provided the child the opportunity to participate in physical activity. The parents had no living relatives, siblings or a support system.

There was no evidence that the parents had a history of DV, mental illness or substance abuse. ACS offered the parents referral for services. However, the parents decided to participate with a community based organization. Shortly thereafter, the parents ceased further communication with ACS and returned to their state of residency.

On 7/1/16, ACS unsubstantiated all the allegations of DOA/Fatality, IG and LMC of the child by the parents. ACS did not complete the Investigation Conclusion Narrative and the agency did not provide justification for the decision to unsubstantiated the allegations.

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:
The casework activity was commensurate with the case circumstances.

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 Specialist gathered sufficient information to make determination for all allegations. The determination made by ACS to unfound the report was appropriate.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The SCR report was dated 2/24/16. ACS completed/approved the 24-Hour Fatality Report on

	2/26/16.
Legal Reference:	CPS Program Manual, VIII, B.1, page 2
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations 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:	Appropriateness of allegation determination
Summary:	ACS did not include narrative to support the determination in the CPS Investigation Summary.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations 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: 02/24/2016 **Time of Death:** 02:04 AM

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

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 12:59 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: watching television

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	Deceased Child	Alleged Victim	Male	10 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	41 Year(s)

LDSS Response

According to the Dr., the child came to the ER at 1:49 AM in cardiac arrest. The child's pupils were fixed and dilated and there was a black residue around the child's mouth. The ER staff performed CPR, intubation and administered emergency medication to the child. The child was worked on for approximately 16 minutes before Dr. declared his death. Upon examination, the child had no trauma to the body. There was a small non-suspicious bruise on the child's ankle. The child appeared healthy with no known medical conditions.

The ACS Specialist obtained the EMS report. The 911 call was received at 12:59 AM. EMS was dispatched at 1:01 AM, arrived on scene at 1:07 AM and made patient contact at 1:10 AM. The EMS stated throughout the child's care, there was no change in his condition. EMS stopped every two flights down for re-evaluation of CPR and interventions given to the child. EMS left the scene with the mother at 1:42 AM. EMS continued resuscitation efforts on the child while in the ambulance to the hospital.

ACS learned that the father was escorted to the hospital by LE. The home was not deemed a crime scene. No arrests were made. The family resided between an out of state home and NYC. The NYC apartment had belonged to the MGM, who died approximately two years prior to 2/24/16. The family attempted to keep the MGM's apartment; however, they were ordered to vacate the apartment by April 2016.

The Specialist conducted a home visit and assessed the child's living environment on 2/24/16. The parents revealed the family's permanent residence was out of state. The parents affirmed the family stayed in the apartment of the deceased MGM for two weeks. The parents clarified the sleeping arrangements. The parents shared a full sized bed in the living room and moved the twin bed from the bedroom since the child was ill; room to be closer to the parents.

The ACS staff interviewed the parents separately. The parents provided similar accounts of the events prior to the child's death. The child was described as a good kid with a healthy appetite with no food or medication allergies. The mother said the day of the incident the child appeared weaker; therefore, she gave the child multiple doses of the over-the-counter medicine during the short timeframe. Despite knowing both sides of their family had a history of preexisting medical illness, the parents admitted the child was last seen by a Dr. and a mobile dentist in 2012. The child was believed to be healthy. The child received online home instruction since Kindergarten. The parents denied use of physical discipline on the child.

On 3/15/16, the online education staff explained to reduce the risk of the students, there was no live video involved. The classes were conducted in real-time via online voice chat. There was no opportunity for instructors to see the child in real time. Reportedly, the child did well in school. The staff reported an outreach worker made periodic home visits to the family home. Although ACS attempted, no contact was made with the outreach worker.

The medical records showed the child was last seen by the Dr. in 2012. During the physical exam the child received

vaccinations, weighed 76 lbs. and was 50 inches tall. The exam did not note the child was obese and there was no plan to address his weight issue in the physical exam.

ACS obtained a medical consultation to review the child's medial history. The medical consult obtained stated the 2012 physical exam suggested that the child was obese with a body mass index (BMI) of 21.3, which is at the 98th percentile for a 7-year-old child.

According to the ME, there were no signs of criminality observed during the physical examination of the child. The child did not have suspicious marks or bruises and was overall a well-child at 116 lbs. and 57 inches tall. On 7/1/16 the ME provided a preliminary finding and the further studies were pending for the final autopsy report.

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)?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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
025901 - Deceased Child, Male, 10 Yrs	025902 - Mother, Female, 41 Year(s)	DOA / Fatality	Unsubstantiated
025901 - Deceased Child, Male, 10 Yrs	025902 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Unsubstantiated
025901 - Deceased Child, Male, 10 Yrs	025902 - Mother, Female, 41 Year(s)	Lack of Medical Care	Unsubstantiated
025901 - Deceased Child, Male, 10 Yrs	025903 - Father, Male, 49 Year(s)	DOA / Fatality	Unsubstantiated
025901 - Deceased Child, Male, 10 Yrs	025903 - Father, Male, 49 Year(s)	Inadequate Guardianship	Unsubstantiated
025901 - Deceased Child, Male, 10 Yrs	025903 - Father, Male, 49 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
During the investigation, ACS made pertinent collateral contacts and conducted investigative interviews related to the case circumstances.

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	Offered,	Offered,	Needed	Needed	N/A	CDR

	After Death	but Refused	Unknown if Used	but not Offered	but Unavaliable		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:
ACS offered referral for bereavement and burial assistance to the parents. The ACS case record did not establish whether the family accepted the referral.

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 surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There were no identified immediate needs related to the fatality.

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

The family had no 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.

Services Open at the Time of the Fatality

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.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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