Child Fatality Report

Report Identification Number: NY-16-086

Prepared by: New York City Regional Office

Issue Date: Mar 21, 2017

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 **Jurisdiction:** Queens **Date of Death:** 08/17/2016
Age: 1 year(s) **Gender:** Male **Initial Date OCFS Notified:** 08/17/2016

Presenting Information

The 8/17/16 SCR report alleged the MGF gave the 22-month-old SC, a whole fruit to eat on 8/17/16. The SC began to choke on the fruit and turned blue. The amount and size of the food that the MGF gave the SC was not appropriate for the SC's age. The MGF called the SM into the room when the SC turned blue. The MGF tried to call 911 but hung up as he thought it would be quicker to be driven to the hospital. The SM, MGF and the SC were transported to the hospital by a friend. The SC was dead when he arrived at the hospital. The SC was pronounced dead on 8/17/16 at 5:00 PM. The SC died as a result of choking on the fruit. It was unknown if the SM was aware that the MGF gave the SC a whole fruit to eat, therefore her role was unknown. The BF and the 5 and 6-year-old siblings were not present during the incident, therefore their roles were also unknown.

Executive Summary

The 22-month-old male SC died on 8/17/16. The ME listed the cause of death as asphyxia due to obstruction of airway by foreign body ("longan pit") and the manner as accident.

The allegations of the 8/17/16 report were DOA/Fatality and IG of the SC by the MGF.

According to the ACS case record the SC, SM and MGF arrived at Queens Hospital around 4:43 PM on 8/17/16. The hospital staff attempts to resuscitate the SC were ineffective and the SC was pronounced dead at 5:00 PM.

The family was identified as having limited English proficiency. During the investigation, ACS utilized an interpreting service to communicate with the family regarding the circumstances surrounding the SC's death. The BF reportedly resided in a foreign country.

According to ACS findings, the SM, MGPs, SC were in the home at the time of the incident. The SM described the SC as a delightful and happy child who enjoyed eating the fruit as he had done on numerous occasions before his death. The SM always had the SC spit out the pit (identified in the ME's report as "Longan Pit") into her hand after he ate the fruit. On 8/17/16, the SM described on two occasions, as she had done in the past; she peeled the skin off the fruit and gave it to the SC and she observed the SC spit the pit out into her hand. The SC went outside to play with the MGF. Upon the SC's return to the home, the SC asked for another fruit. In the third instance, the SM peeled the fruit, gave it to the SC and he walked off to the bedroom with the MGF. The SM continued to prepare the family's meal. Shortly thereafter, the MGF came out of the bedroom and alerted the SM that the SC was not breathing. The SM went into the bedroom and observed the SC laying face down on the floor. The SM picked up the SC from the floor; she described the SC's body felt tense and his face was a dark color when she put the SC over her arm and patted the SC on the back. The SM made another attempt to dislodge the fruit pit; she put her fingers down the SC's throat, yet the effort was unsuccessful. The MGF struggled to call 911 on the phone as there was weak cellular reception in the basement apartment. The MGF then went upstairs to attempt another 911 call from the neighbor's phone; however, the neighbor suggested that the family transport the SC to the hospital. The upstairs neighbor drove the SM, MGF and SC to the hospital. The SM said it took 5 minutes to arrive at the hospital and the hospital staff worked on the SC until he was pronounced dead.

ACS opened the Family Services Stage (FSS) of the case to provide the family with preventive services on 8/23/16. The family sent the two siblings to reside with the PAs out of New York State. ACS contacted Polk County Child Protective Services (CPS) and requested an out-of-state courtesy home visit and safety assessment for the siblings on 8/29/16. The county CPS observed the siblings in the PAs care and provided ACS with a comprehensive report. The report showed the CPS had observed the siblings in the PAs' care and there were no safety concerns. ACS closed the FSS stage on 8/31/16 as there were no children in the care of the SM.

The ACS case record did not reflect that agency obtained nor updated the identifying information for the adults who resided in the household.

On 1/13/17, ACS added to the 8/17/16 report the allegations of IG and LS of the SC by the SM. ACS substantiated he allegations of IG and LS of the SC by the SM on the basis the SM inappropriately gave the SC a fruit with a large pit and allowed the SC to leave her presence without properly supervising the SC spit the pit into her hand as he had done in the past and earlier that day. ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the MGF. ACS noted that according to the information gathered from the SM, hospital and LE, the SC choked on a fruit pit and the manner of death was listed as an accident.

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?** — No

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:

N/A

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:

N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-Hour safety assessment was not approved within 24 hours for the report. The selected safety factor and the comment was contrary to the caretaker actions.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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:	Timely/Adequate Seven Day Assessment
Summary:	A 7-Day safety assessment was not completed during the investigation.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Fatality Report and the corresponding safety assessment were not approved within the required timeframe from the SCR report date.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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:	Contact/Information From Reporting/Collateral Source
Summary:	There was no progress note documentation of efforts to contact or interview the MGM or BF.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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:	Failure to provide notice of report
Summary:	The notice of report was not provided to the SM and MGF in their primary language. Although the BF was reportedly in a foreign, there was no documentation of ACS efforts to interview of inform him of the investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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:	Failure to Provide Notice of Indication
Summary:	The Notice of Indication was not provided to the SM in her primary language.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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:	Adequacy of case recording
Summary:	The ACS case record did not reflect that agency updated the household composition information in the CONNECTIONS record.
Legal Reference:	18 NYCRR 428.5(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took 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: 08/17/2016 **Time of Death:** 05:00 PM

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

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? No
Did EMS to 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:

☐ Drug Impaired ☐ Absent

☐ Alcohol Impaired
☒ Distracted
☐ Impaired by disability
☐ Asleep
☐ Impaired by illness
☒ Other: Cooking

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	1 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	60 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Other Household 1	Father	No Role	Male	40 Year(s)

LDSS Response

On 8/17/16, the attending Dr. said at 4:43 PM the SM, MGF, SC and family friend arrived at hospital ER. The attending Dr. observed the SC was pulseless. The hospital staff unsuccessfully attempted a blind sweep of a finger down the SC's throat. All attempts to resuscitate the SC were unsuccessful and the SC was pronounced dead at 5:00 PM. The Dr. said there were no marks or bruises observed on SC's body.

On 8/18/16, the ME informed ACS that the SC died of cardiac arrest due to asphyxiation. There were no suspicious signs of abuse observed.

According to LE, the family attempted to call 911; however, due to their limited English proficiency and poor cellular reception, they decided to drive the SC to the hospital. LE stated the SM often fed the SC the fruit in the past. No arrests were made.

On 8/18/16 ACS interviewed the SM and MGF separately. The SM stated on 8/17/16, she supervised the SC as he ate and discarded the pits of two fruits she previously peeled for him. The SM peeled the third fruit, gave it to the SC who walked towards the bedroom. Shortly after, the MGF came out of the bedroom and alerted the SM that the SC was on the floor unresponsive. The SM made two attempts to dislodge the pit, to no relief of the SC. The MGF had no phone reception to call 911. The MGF went upstairs to call from the neighbor's phone. The neighbor advised the family to take the SC to the hospital. A neighbor drove the SM, MGF and SC to the hospital. ACS noted inconsistencies in the statement as the explanation did not include the specific timeline of events nor establish which family member gave the child the fruit.

The Specialist observed the two SS and found they did not have marks or bruises. The Specialist observed the home and assessed the sleeping arrangements were satisfactory. There was an adequate supply of provisions in the home. There were no safety hazards observed in the home. The 6-year-old SS stated he was at school at the time of the incident involving the SC. This SS said the MGM was at home when he returned from camp.

On 8/19/16, ACS staff interviewed the family friend who confirmed the 5-year-old SS had been in her care for 12 days and was in her care at the time of the incident. The family had a pre-arranged agreement for the 5-year-old SS to be in her home until school began in September. The friend was asked by the MGP's to help the family care for the SS as they were unable to manage his behavior. The 5-year-old SS did not have observable marks or bruises.

On 8/23/16, a child safety conference (CSC) was held and the SM attended via telephone. ACS offered bereavement and counseling services. The SM agreed to accept services. The SM informed ACS of the family arrangement made for the two siblings to reside with PAs out of New York state. ACS decided to seek a court action for the return of the siblings to the SM with court ordered supervision (COS).

On 8/24/16, ACS filed an Article Ten Neglect petition in Queens County Family Court to request a COS for the family. The attorney's conclusion stated there was insufficient information to file a petition at that time as the siblings were safe, and the SM had accepted services.

On 9/3/16, ACS received an assessment from Polk County CPS for two siblings. The SM provided guardianship documents to the PA's for the siblings. The siblings were observed. There were no safety concerns regarding the siblings. They were attending school; where they were evaluated for educational, behavioral and therapeutic services.

On 8/18/16 and 12/12/16, ACS documentation revealed the SM and MGF were provide the notice of existence of a report and notice of indication, respectively, in their primary language.

ACS staff interviewed the siblings' Dr. on 1/12/17. The Dr. said there were no concerns regarding the care the SM provided the siblings as there were no signs of maltreatment and their medical evaluations were up to date.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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 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
030761 - Deceased Child, Male, 1 Yrs	034903 - Mother, Female, 36 Year(s)	Lack of Supervision	Substantiated

030761 - Deceased Child, Male, 1 Yrs	034903 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
030761 - Deceased Child, Male, 1 Yrs	030763 - Grandparent, Male, 60 Year(s)	DOA / Fatality	Unsubstantiated
030761 - Deceased Child, Male, 1 Yrs	030763 - Grandparent, Male, 60 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

N/A

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?	☐	☒	☐	☐

Explain as necessary:
Through a family arrangement, the SM relocated the two siblings to reside with PAs out of New York State on 8/27/16.

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:
There was no documentation that burial arrangement service was offered to the family.

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? No
Explain:
Following the child's death, the family sent the siblings to reside with relatives out of New York state. Subsequently, the family refused ACS offer for services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family accepted ACS offer for services. However, the parents did not make themselves available for 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

The family had no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There had no known CPS history outside of NYS.

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