Child Fatality Report

Report Identification Number: NY-17-014

Prepared by: New York City Regional Office

Issue Date: Jul 25, 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	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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	

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 02/07/2017
Initial Date OCFS Notified: 02/07/2017

Presenting Information

On 2/7/17, the SM gave the 6-month-old SC a grape. The SC began to choke and the SM called 911. Upon the arrival of EMS, the SC was conscious and alert. While in the ambulance, the SC went into cardiac arrest. CPR was attempted for one hour, however, the SC passed away. The SC was an otherwise healthy child and at the time of the incident there was no explanation for the SC's death. The SM, SF and PGM were considered the alleged subjects as they were all persons legally responsible for the SC. The roles of the 5-year-old and 1-year-old surviving siblings (SS) were unknown.

Executive Summary

This 6-month-old SC died on 2/7/17. According to the ME, the SC's cause of death was pending further studies. As of 7/5/17, NYCRO has not yet received the autopsy report.

The allegations of the 2/7/17 report were DOA/Fatality and IG of the SC by the SM, SF and MGM.

The SM described the timeline of events leading to the incident. On 2/5/17, the SM recalled the SC appeared to be in good health. At approximately 3:00 PM, the SC's forehead was warm and he had no signs of malaise. The SM placed a wet cloth on the SC's forehead and the SC's temperature decreased to 99 degrees. The SM thought the SC's temperature would continue to decrease. On 2/6/17 the SC went to sleep at midnight and woke up around 8:00 AM. The MGM fed the SC a bottle of milk. The MGM observed the SC seemed ill. The MGM gave the SC some grapes. The SM explained that the grape was peeled, cut into pieces and mashed, and fed to SC. At approximately 10:30 AM, the SM called the Dr.'s office as the SC feeding regimen had unusually changed; however, the Dr. was not in the office. Around 11:00 AM, the SM heard the MGM scream. The SM noticed the SC was in distress and had turned blue. The SM assessed if the SC was breathing and used her finger to sweep out the SC's mouth. The SM called EMS at approximately 11:15 AM. Upon EMS' arrival, the SC appeared alert as the SC was carried to the ambulance; however, once in the ambulance the SC's eyes appeared widened. The EMS worker informed the SM the SC was fine. Shortly thereafter, the SC's color begun to change. EMS performed CPR on the SC. Upon the ambulance's arrival at the hospital, the ER staff continued resuscitation measures until the SC was pronounced dead at 1:01 PM.

According to the ACS case record, the SM and SF were in the process of moving at the time of the incident. ACS observed the children did not have adequate sleeping arrangements. The parents made a family arrangement for the two SS to temporarily reside in the home of the MA; to assist with parents with supervising the two SS.

During the investigation, the ACS Specialist made relevant contacts and sufficient face-to-face contacts with the parents and the two SS in the home. The family was cooperative and receptive of offered bereavement services, Early Intervention and burial assistance. ACS opened the Family Services Stage (FSS) on 2/8/17 and provided the family with case management services. The family received therapeutic services through a Community Based Organization.

On 4/7/17, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SM, SF and MGM on the basis that no credible evidence was gathered to support a finding of abuse or maltreatment by the parents. According to the Dr., no foreign body was found in the SC's mouth area and there were no obvious signs of abuse observed on the SC's body. ACS did not address the allegations of DOA/Fatality and IG of the SC by the MGM in the Investigation Conclusion narrative.

On 4/18/17, ACS assessed the two surviving siblings in the family home to be safe, well cared for, and free of marks

and bruises. The family had appropriate sleeping arrangements for the two siblings. As of 7/25/17, the FSS remained open for monitoring.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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

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 Case Recording/Progress Notes
Summary:	ACS did not enter some of the progress notes within the required 30-day timeframe. There were progress notes entered on 4/7/17 for events that occurred on 2/7/17, 2/8/17, 2/10/17 and 2/16/17, respectively.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a performance improvement 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:	ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the MGM. However, in the Investigation Conclusion Narrative, ACS did not include information to support the decision to unsubstantiate the allegations.
Legal Reference:	18 NYCRR 428.5(c)
Action:	ACS must submit a performance improvement 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: 02/07/2017 **Time of Death:** 01:01 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? Yes
Time of Call: 11:32 AM
Did EMS to respond to the scene? Yes
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: 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	Female	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	60 Year(s)
Deceased Child's Household	Mother -	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

On 2/7/17, LE observed there was no trauma on the SC's body. LE said the SM stated the SC was not eating well for two days. LE stated the autopsy was pending and the police investigation was ongoing. There were no arrests made. According to LE, a crib was not observed in the home. The two SS appeared to have received adequate care.

ACS conducted a home visit and assessed the two SS for safety. The two SS were observed free of marks and bruises. The 1-year-old was comforted by the parents and the 5-year-old SS appeared fatigued. Later, the 5-year-old SS was taken to the ER where he was diagnosed and treated for an illness.

According to the hospital attending Dr. at the Flushing Hospital, there were no obvious signs of trauma to the SC's body. The Dr. said the SC died of cardiac arrest. The Dr. did not observe any grapes in the SC's mouth area. An x-ray showed the SC had a medical condition which probably contributed to the SC's lack of weight gain. The Dr. suggested the 5-year-old SS's recent illness may have exacerbated the SC's underlying medical issues.

According to the family Dr., all the children's immunizations were up to date. The SC was healthy and weighed 18 lbs. when last seen on 1/17/17. The Dr. had encouraged the SM to begin the SC on solid foods. The 1-year-old SS was previously diagnosed with a medical condition for which the parents appropriately ensured the SS received medical care and prescribed medication.

The SM stated that at the advisement of the family Dr., the SM began the SC on solid foods about a week prior to 2/7/17; the diet consisted of mashed apples and grapes, and the SC's intake of milk had started to decrease. The SM was not alarmed by the SC's change in milk consumption as the SM thought it was due to the introduction of solid foods.

The SF stated he was at work at the time of the incident. He received a telephone call from the SM regarding the SC and left work. The SF and EMS arrived to the case address simultaneously. The SF stated the SC was alert when she went into the ambulance with the SM. The SF followed the ambulance to the hospital in the family vehicle.

According to the MGM she was visiting to help the family care for the children. On the day of the SC's death, the MGM notified the SM that the SC was not drinking the formula as usual and decided to feed the SC mashed pieces of fruit and water. The MGM decided to feed the SC mashed grapes as the grapes were the only food the SC had easily digested since 2/6/17. Shortly thereafter, the MGM reported the SC spit out the grape. The MGM encouraged the SM to contact the family's Dr.. Later, the MGM observed the SC's face turned pale and lips were purple. The SM called 911. The MGM and SM thought there was a lodged object in the SC's throat. Both attempted to clear the SC's airway with their fingers. EMS arrived and transported the SM and SC in an ambulance to the hospital. The MGM stayed with the two SS in the home.

On 2/8/17, ACS held an Initial Child Safety Conference (ICSC) at the ACS office. The SM, BF and MGM attended and a language interpretation telephone service was utilized. ACS and family members discussed the events leading up to the SC's death and ACS plan for filing an Article Ten Neglect petition on behalf of the two SS. A safety plan was developed for the two SS.

ACS attempted to file an Article Ten Neglect Petition. The ACS attorney stated ACS had no information regarding how an otherwise healthy infant died as the SC's Dr. said there was no sign of child abuse and neglect of the SC. The case was delayed for further information particularly the autopsy report or preliminary findings of the medical examiner.

On 2/10/17, the FSS was opened and the family was referred to a Community Based Organization for services.

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
036312 - Deceased Child, Female, 6 Mons	036317 - Grandparent, Female, 60 Year(s)	Inadequate Guardianship	Unsubstantiated
036312 - Deceased Child, Female, 6 Mons	036315 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
036312 - Deceased Child, Female, 6 Mons	036315 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
036312 - Deceased Child, Female, 6 Mons	036316 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
036312 - Deceased Child, Female, 6 Mons	036316 - Father, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
036312 - Deceased Child, Female, 6 Mons	036317 - Grandparent, Female, 60 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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:
ACS' attempt to seek an Article Ten Petition was not accepted. The ACS attorney stated there were no safety concerns regarding the SS; therefore, court intervention was not necessary. The SM and BF arranged for the family to temporarily reside in the MA's home to receive emotional support and assist the parents in supervising the two SS.

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:
As of 6/22/17, the case remained open for PPRS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family temporarily resided in the MA's home. The MA provided emotional support and assisted the parents in

supervising the two SS.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

The family had 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.

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