Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-17-004

Prepared by: New York State Office of Children & Family Services

Issue Date: Aug 10, 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	yo- year(s) old

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 03/23/2017
Initial Date OCFS Notified: 03/23/2017

Presenting Information

SCR report alleged on 3/23/2017, the 3-year-old SC passed away while in the care and supervision of the PGM. The cause of death was unknown. The SC was diagnosed with Leptin Receptor Deficiency, which causes a person to lack the ability to determine when they are physically full when eating. The SC weighed 100 pounds at the time of his death. The SC also had a history of Croup. The SM, SF, PGF, PGM, and PA were all responsible for the SC's care on a daily basis. The SC was fine during the day while the SF was home. On the evening of 3/23/2017, the SF called for emergency medical assistance at 7:50pm. The SC was found unresponsive on the bedroom floor in cardiac arrest by medical staff at 7:55pm. Medical staff were unable to revive the SC and he was transported to the hospital where he was pronounced dead.

Executive Summary

This report concerns the death of the 3-year-old male SC, who was reported to have died for unknown reasons during a time he was in the care of PGM. Monroe County Department of Human Services (MCDHS) was assigned to investigate the death due to a report received by the SCR on 3/23/2017. MCDHS investigated allegations made against all regular caregivers of the SC, which included SM, SF, PGM, PGF, and PA.

In the first 24 hours, MCDHS searched Child Protective Services (CPS) records and found there to be no history. MCDHS attempted contact with LE but did not reach them until 4/5/17. Interviews of the parents were conducted by MCDHS on 3/27/17. Although the report alleged there were no OC in the home, MCDHS did not confirm this in the first 24 hours. During that time, MCDHS did not make contact with the source or LE who was in the home, and though they spoke with the SF, he was not asked about SS or OC.

When MCDHS saw the family at their home, the parents refused to discuss the case, sign releases, allow CW to speak to relatives, or meet further with CPS. Most information learned was from LE records regarding their response and interviews. LE interviewed SF, and PGM by way of SF interpreting for her (she did not speak English). MCDHS learned the SF and PGF were at the library and the SM and PA were at work, while PGM watched SC on the night of the incident. It was only about 20 minutes that he was gone when SF received a call from PGM reporting SC was having trouble breathing. SF then called 911 to the home, and PGM called shortly after to report SC was vomiting blood and secreting blood from his nose. SF called 911 again. EMS were unable to revive SC, and he was transported to the hospital where he was pronounced deceased.

The SC had a common childhood respiratory condition one year prior, and he also had a genetic disorder known to cause overeating and other abnormal food-related behaviors. As there were no releases upon which MCDHS had the ability to speak to medical providers, it was unknown if SC's past or present conditions caused the circumstances leading up to his death. LE records noted SF reportedly took SC to the pediatrician two days before his death and he stated there had been no concerns. It was unclear whether LE obtained any medical documentation and/or shared it with MCDHS.

LE observed the home on 3/23/17, noting it was "neat and orderly," with, "no apparent signs of blood in the area." They noted, "It appeared that (SC) was set up to sleep on the floor in the master bedroom on a number of blankets and pillows," and described, "over the counter medications (were) found in the 'sleeping' area." Items were secured for evidence.

MCDHS learned two weeks into the investigation that LE had closed their case without concerns or suspicions regarding the death. Although the requested autopsy report was not complete, MCDHS learned from the ME's office that they too had no concerns or suspicions regarding the death. The official cause and manner of death remained pending.

Follow-up interviews of family members and further information from collaterals could have been essential to the CPS investigation as to whether there were any concerns for abuse or maltreatment, even though there were no outward signs. Without the ability to do either, MCDHS consulted supervisors and the legal department and it was determined there was no legal basis to take the matter to Family Court.

MCDHS closed and UNF the report. The determination was based on a lack of credible evidence to support that the alleged subjects failed to provide a minimal degree of care, or that they contributed to SC's death.

The 7-day safety assessment was not completed. In response to the citation, MCDHS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days. The PIP will identify what action MCDHS has taken, or will take, to address this. If a PIP is currently in place, MCDHS will review the plan and revise as needed.

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?** 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

Explain:
There were no surviving children, and the initial and final safety assessments documented that as the reason there were no safety factors. The decision to unfound the report was appropriate given the information that was able to be gathered.

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 level of casework activity was commensurate with case circumstances. There was documentation of supervisory consultation.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	There was no 7-day safety assessment completed.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	MCDHS will complete all safety assessments and accurately reflect the safety factors that are or are not present.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/23/2017 **Time of Death:** 09:09 PM

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 07:50 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
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? Unable to determine

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	Aunt/Uncle	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	54 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	48 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

The SCR report was made late in the evening on 3/23/17. The report referenced the death of the SC due to unknown reasons, after he had been in the care of his PGM. The report noted illnesses that the SC was alleged to have (chronic and acute). The report stated there were no other children in the home. On 3/24/17, within 24 hours, MCDHS received direction from a supervisor, sent a request for an autopsy report, and attempted contact with LE to coordinate an investigation. A CPS history check done on this date revealed no known history for any of the family members. MCDHS also made phone contact with the SF. In this contact, MCDHS offered condolences, explained the role of CPS, and scheduled a home visit and interviews for 3 days later. MCDHS did not inquire of the SF or find any information to confirm whether there were SS or OC in the home; thus, key information was not obtained to accurately assess whether there were any surviving children within the first 24 hours of the report. Additionally, the 7-day safety assessment was never completed.

MCDHS made face-to-face contact with the family on 3/27/17, bringing an interpreter as there were family members who did not speak English. It appeared that all household members were present that day. Though there was a communication barrier, the family refused the interpreter's assistance. The CW spoke with the parents, but aside from offering condolences, the CW was unable to elicit any pertinent information as the parents refused to speak of anything. The parents stated they were only interested in getting information as to how their son died. MCDHS requested the parents sign releases for information, but they but refused. The parents would not allow MCDHS to speak with anyone else in the home.

MCDHS learned some essential information from the police reports regarding the incident. According to interviews LE had with the family, the following information was learned: The SC had a preexisting genetic disorder that is known to cause over-eating, thus the SC weighed over 100 pounds. He also had a history of hospitalization for an acute illness, known to cause excessive coughing, wheezing, and trouble breathing, but he had not had symptoms in over a year. LE interviewed SF, then PGM was interviewed using the SF as an interpreter. The SF reported SC was seen by his pediatrician on 3/21/17 and had been given a "clean bill of health." On 3/23/17, the SC was home alone with the PGM while the SF and PGF were at the library and the SM and PA were at work. According to the SF and PGM, it had only been about 20 minutes that she was alone caring for the SC when he began wheezing. She called the SF and told him SC was having trouble breathing. SF called 911 to his home for assistance and proceeded to the house. While en route, PGM called him a second time reporting the SC had begun bleeding from the nose and vomiting blood. The SF called 911 a second time. EMS was at the home when SF arrived, and he learned the SC's condition was grave. SC was pronounced deceased at the hospital after failed efforts to resuscitate him.

Follow-up questions regarding the death as well as other information related to safety and risk remained unanswered as the SF refused MCDHS' two requests to interview the family, in addition to the fact that there was no access to the SC's medical records. Though the autopsy report was requested and not complete at the time of this report, MCDHS learned in a phone call that the ME reported no suspicions or concerns about the SC's death. The determination of all allegations, DOA/Fatality, IG, and IF/C/S against all 5 caregivers, were Unsub as MCDHS found no credible evidence that they failed to provide the SC with a minimum degree of care, or that they committed acts of commission or omission that contributed to his death.

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: There was correspondence between MCDHS and the Monroe County Sheriff's Office. Although some information was shared, it appears the investigations were conducted separately.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The fatality was reviewed by the Monroe County CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039121 - Deceased Child, Male, 3 Yrs	039123 - Father, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039123 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039122 - Mother, Female, 22 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039125 - Grandparent, Female, 48 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039126 - Aunt/Uncle, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039124 - Grandparent, Male, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039124 - Grandparent, Male, 54 Year(s)	DOA / Fatality	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039125 - Grandparent, Female, 48 Year(s)	DOA / Fatality	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039122 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039126 - Aunt/Uncle, Female, 24 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039124 - Grandparent, Male, 54 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039122 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039126 - Aunt/Uncle, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039125 - Grandparent, Female, 48 Year(s)	Inadequate Guardianship	Unsubstantiated
039121 - Deceased Child, Male, 3 Yrs	039123 - Father, Male, 26 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
Caretakers / Babysitters	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Other	☐	☒	☐	☐
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?	☐	☒	☐	☐

Additional information:

Several first responders were not contacted. Attempts were made to interview subjects, though they refused. Efforts were made to get releases of information for the SC's medical care but the parents refused. No 7-day safety assessment was completed.

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	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:
Since the parents were uncooperative in speaking with MCDHS, it is unknown as to whether the family was in need of any additional services. MCDHS was able to have a brief conversation with the parents; however, no services related to the fatality were offered.

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 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:
Services were neither offered nor provided; however, the family refused to speak with MCDHS about any matters regarding their family.

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? No

CPS - Investigative History Three Years Prior to the Fatality

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

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

There was no CPS history for any of the family members more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history for any of the family members outside of New York State.

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

Additional Local District Comments

MCDHS disagrees with this recommended action, as the information regarding no surviving siblings was received by a partner in our MDT and there is no law or regulation that states more is needed.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☒Yes☐No

Action:	It is recommended that within the first 24 hours, MCDHS will make diligent efforts to confirm whether there are surviving children in the home, even if the report names no other children. Though the report alleged there were no other children in the home, the record does not reflect whether MCDHS made diligent efforts to confirm this in the first 24 hours. During that time, MCDHS did not make contact with the source, and did not ask SF, with whom they spoke by phone.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No