NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-042 **Prepared by: New York City Regional Office**

Issue Date: 11/10/2015

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	MN-Medical Neglect	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: 2 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 05/24/2015
Initial Date OCFS Notified: 05/26/2015

Presenting Information

According to the OCFS notification from PPRS agency New Alternatives for Children (NAC), on the evening of 5/24/15 the Social Worker (SW) received a call from the BM. The BM stated that at 9:30pm she was scheduled to give the SC his medication and noticed he was not-responsive in the crib. She attempted to provide CPR to the SC and he was still non-responsive. She contacted the hospice nursing supervisor from Metropolitan Jewish Hospice Services (MJHS) who made a telephone assessment of the child's condition. MJHS staff instructed BM she had the option of calling 911 or waiting for hospice staff to assist. BM elected hospice staff response who arrived at the home and prepared the SC for the coroner.
The SC was a 2-yr-old medically fragile child who was expected to pass away the prior year. All the medical providers were aware of SC's medical fragility.

Executive Summary

On 11/14/13 a report was made to the SCR alleging medical neglect of the SC by the BM and BF. The SC was born prematurely and when three months old, was diagnosed with medical health conditions that left him neurologically impaired, required a feeding tube and a shunt; he was medically fragile. The report alleged the parents failed to ensure the SC received appropriate follow up care which resulted in the SC undergoing surgery to replace a shunt designed to drain excess fluid off his brain.

The allegations of this report were Unfounded against both parents. CPS concluded there were barriers to the parents ability to care for the SC. The family lived in a NYC Department of Homeless Services (DHS) shelter; they were moved to different shelters and given the locations, it was difficult to keep medical appointments for the SC at two hospitals. CPS appropriately referred the family for FPP crisis intervention services during their investigation. FPP crisis intervention services were put in place to assist the family with resources, support, as well as the care for the medically fragile SC. FPP referred the BM to an appropriate support group that both the BM and BF attended. In collaboration with the hospital social worker, FPP referred BM for VNS services -- BM initially refused VNS services but accepted VNS on 12/13/13. The parents remained in compliance with VNS services. FPP referred the SC for Early Intervention evaluation and documented the outcome -- he would benefit from physical and occupational therapy.

Referral for PPRS had occurred on 12/7/13. On 12/18/13, FPP held a services termination conference with the family. Upon expiration of FPP services, a closing conference was held on 12/18/13. FPP also convened a transitional conference with the Bronx CPS on 1/10/14. During this conference, FPP reported the SC was waitlisted for a medically fragile PPRS program due to the specificity of his medical needs. On 2/7/14, a successful joint home visit by FPP and the PPRS agency New Alternatives for Children (NAC) CP/SW occurred.

On 4/16/14, a subsequent report was made to the SCR alleging Inadequate Guardianship of the SC by the BF. It was alleged BF assaulted the BM in the presence of the SC. This report was Indicated; the BF was arrested with an OOP issued against him for the BM and SC. According to case documentation, the OOP expired on 5/20/14.

In July 2014 the CP, Montefiore hospital treatment physician, social worker, BM and BF participated in a meeting to discuss the SC's health condition and treatment plan. The parents agreed to hospice services as they were aware of the SC's long term prognosis. The family accepted hospice services through Metropolitan Jewish Health System (MJHS). The family recieved Home Health Aide (HHA) services that initially occurred for 3 hours a day, 5 days a week and was increased to 8 hours a day, 3 days a week. 1/15/15 progress notes stated the SC's treatment plan was amended to palliative care as his medical condition stabilized; in-home services were provided by the HHA instead of bi-weekly hospice nurse services. The family received respite services from MJHS. The SC spent 5 days at a children's residential facility located in Brooklyn. The facility had sleeping accommodations for the parents, and the BF stayed with his son for those 5 days.

On 5/24/15, while supervised by his BM, the SC passed away.

CPS and PPRS agency, NAC, took appropriate measures to provide for the SC's safety and medical care. CPS and NAC illustrated good agency practice by maintaining frequent communication with the SC's hospital medical treatment staff and including MJHS, the HHA and VNS staff. Case work contacts occurred with the SC and his parents. The NAC CP and supervisor were very empathic with the BM after the passing of the SC; they attended the SC's funeral on 6/4/15.

The case was appropriately closed; there were no surviving siblings or other children in the home.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Hospice care was provided to the SC as his death was anticipated.

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:
Case was appropriately closed in that the circumstances no longer met the eligibility standards for preventive services. That is, there were no surviving siblings and/or children in the home.

Required Actions Related to the Fatality

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

Issue:	Timeliness of completion of FASP
Summary:	The Reassessment FASP due date was 6/13/15. NAC submitted it for approval on 6/11/15. NAC and ACS Case Manager Invalidated the FASP on 6/15/15. NAC resubmitted and approved the FASP on 6/15/15. ACS final approval - 6/16/15.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a corrective action plan to OCFS within 45 days that identifies the agency's action to address the identified issue. It must include each agency's policy/procedures regarding timeliness of FASP approval. NAC and ACS must also meet with pertinent program staff and inform OCFS of the date of the meeting, who attended, what was discussed, and the action plan.
Issue:	Provide preventive services according to the needs of the child and the child's family
Summary:	NAC did not document assessment of, or services referral for the BF who was Secondary Caretaker, prior to or post the SC's death. The BF was involved with the SC's life up to his death.
Legal Reference:	18 NYCRR 423.4(a); SSL 424 (13)
Action:	ACS must submit a corrective action plan to OCFS within 45 days that identifies the agency's action(s) to address the identified issue. It must include NAC's policies to engage fathers and documentation of their services need. NAC must meet with program staff and inform OCFS of the date of the meeting, who attended, what was discussed, including an implementation and monitoring plan.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/24/2015 **Time of Death:** 09:30 PM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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

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	No Role	Male	2 Year(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)

LDSS Response

PPRS staff conducted a home visit upon learning of the SC's death. The CP/SW was empathic and provided emotional support for BM while she grieved for her only child during the HV. The CP/SW documented the family was able to obtain funds for funeral costs through the 'Go Fund Me' website. On 6/4/15, the NAC CP/SW and supervisor attended the SC's funeral.

NAC appropriately determined the family's circumstances no longer met the standards for preventive services in that there were no siblings/children living in the home. The case was closed in CONNECTIONS on 6/30/15.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Not Applicable.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine

All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Family Members	☐	☐	☐	☒
Other	☐	☐	☐	☒
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
There was no SCR report that alleged DOA/Fatality of the SC; therefore, there was no CPS investigation.

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

Have any Orders of Protection been issued? No

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:
Case was appropriately closed on 6/30/2015 after the death of the SC in that there were no other children in the home. There was no documentation the agency offered bereavement services to the parents after the child's death.

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 in the household; SC was an only child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
NAC provided immediate casework counseling support to BM during the home visit after the SC's death. However, NAC did not document offering either the BM or BF bereavement counseling services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/14/2013	5151 - Deceased Child, Male, 6 Months	5153 - Father, Male, 24 Years	Lack of Medical Care	Unfounded	No
	5151 - Deceased Child, Male, 6 Months	5152 - Mother, Female, 24 Years	Lack of Medical Care	Unfounded	

Report Summary:
On 11/14/2013 a report was made to the SCR regarding the SC's hospitalization. It was alleged that due to the lack of care and follow up of medical appointments by the parents, the SC presented with medical issues that could have been avoided. The SC was diagnosed with bacterial meningitis at birth which left him neurologically impaired. The child was in need of the necessary follow up care to drain the fluid that collected on his brain through his shunt.

Determination: Unfounded **Date of Determination:** 12/10/2013

Basis for Determination:
CPS determined that the allegation of LMED was UNF against BM and BF. CPS concluded after speaking with the SC's medical providers that the parents had both done their best to meet the medically fragile SC's needs. The family's financial situation along with their lack of stable housing played a role in hindering the SC's medical appointments being met in a timely fashion. CPS referred the family for ACS' Family Preservation Program (FPP) crisis intervention services that were accepted; FPP was working diligently to get all services in place.

OCFS Review Results:
CPS made the appropriate determination for this report in that there were financial conditions/factors that led to the inability of the parents to meet the required needs of the SC. Family agreed to FPP services to assist with the SC medical care going forward.
Safety assessment and risk assessments were in alignment with case circumstances. Appropriate collateral contacts, including medical contacts were made.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/16/2014	5363 - Deceased Child, Male, 2 Years	5362 - Father, Male, 24 Years	Inadequate Guardianship	Indicated	No

Report Summary:
The SCR report alleged IG against the BF for the SC; BM had no role. According to the intake narrative, on 4/15/14 about 1:30am the BF asked the BM for money. When BM refused, BF threatened BM, took her phone and punched her multiple times in the face. This occurred in the presence of the SC, placing him at risk. The police intervened and BF was arrested. Additional Info: BF was arrested and released, whereabouts unknown at the time.

Determination: Indicated **Date of Determination:** 05/20/2014

Basis for Determination:
CPS determined the allegations were SUB against BF for IG. That BF fought with BM in the presence of the SC, placing

him in harm's way. BF was arrested and criminal charges were pending against him. The report was IND. Closure Reason: Closed - Case Open, CPS Required.

OCFS Review Results:
CPS' investigation and determination of this report was appropriate.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/06/2015	5335 - Deceased Child, Male, 2 Years	5336 - Mother, Female, 26 Years	Inadequate Guardianship	Unfounded	No
	5335 - Deceased Child, Male, 2 Years	5336 - Mother, Female, 26 Years	Lack of Supervision	Unfounded	

Report Summary:
The report alleged IG and LS by the BM against the SC. The intake narrative stated BM regularly left the SC, who was 1-yr-old at the time, alone without adult supervision and unattended in the room of the shelter where they were residing. That the child was at greater risk of harm at those times and required a higher level of supervision; he had medical problems with respiratory and circulatory systems making him more at risk for choking or suffocating. The BM was leaving the child alone in the room, exiting the building for unspecified lengths of time.

Determination: Unfounded | **Date of Determination:** 04/06/2015

Basis for Determination:
CPS determined that the allegations of IG and LS were UNSUB against BM. CPS learned from the medical provider that the SC's diagnosis did not include respiratory issues. Also, the BM did leave the SC alone in the shelter room located on the 3rd floor of the facility. The room did not provide cooking appliances, the restroom was located outside her room, and the cafeteria was in the basement. This situation posed great difficulty for BM to meet her and the SC's needs. The shelter staff did not assist BM. CPS successfully advocated for the family's relocation to a more conducive shelter, and apprised shelter staff of the family's circumstances.

OCFS Review Results:
Regarding this report, CPS appropriately advocated and took necessary actions to support and address the family's needs.

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

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

The family does not have CPS history more than three years before the fatality.

Known CPS History Outside of NYS

The case documentation did not indicate the family had CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 11/14/2013

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 11/14/2013

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? Reassessment FASP due date 6/13/15 approved 6/16/15.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
Crisis Intervention services were provided by ACS FPP from 11/23/13 to 12/19/13. The family was referred to New Alternatives for Children (NAC), Medically Fragile preventive program at conclusion of FPP. Joint home visit occurred with FPP, NAC, BM, & BF on 2/7/14. Hospice services were provided by MJHS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

On 11/14/13 an SCR report alleged LMC of the SC by his parents. The report alleged the parents failed to follow up with scheduled medical appointments resulting in the SC's hospitalization. On 11/15/13, the family was referred to ACS FPP crisis intervention services following a Child Safety Conference. The SC had extensive medical needs and was considered medically fragile.

The family's circumstances stabilized and FPP referred the family to New Alternatives for Children (NAC) medically fragile preventive program on 12/7/13. Joint home visit occurred on 2/7/14 with BM, BF, SC, and NAC's Case Planner (CP)/Social Worker (SW). NAC's SW, nurse (RN), and doctor collaborated with the SC's medical treatment team during and post his hospitalizations. The SW and RN conducted home and hospital visits that included a palliative care specialist meeting at the hospital, and meeting with shelter staff regarding housing. Ongoing communication occurred with the VNS, home health aide, hospice care staff, respite care staff, shelter staff, & CPS. Advocacy and referrals occurred when appropriate.

SC had remained stable for the last 6 months of his life. However on 5/24/15, the SC succumbed to his illness and passed away in his sleep.

Family Assessment Service Planning (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent required FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? Reassessment FASP due date 6/13/15 approved 6/16/15.				

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?

☐Family Court ☒Criminal Court ☒Order of Protection

Criminal Charge: Assault **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	BF	Unknown	Charges were dropped
Comments:	The case record stated there were assault charges against the BF that were later dropped by the BM.		

Have any Orders of Protection been issued? Yes	
From: 04/15/2014	**To:** 05/20/2014

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