Child Fatality Report

Report Identification Number: NY-17-046

Prepared by: New York City Regional Office

Issue Date: Nov 02, 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	OA-Other Adult	
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
CPS-Child Protective Services		
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
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 05/07/2017
Initial Date OCFS Notified: 05/07/2017

Presenting Information

The SCR registered two reports (an Initial and a Subsequent) regarding the SC's death on 5/7/17.

The Initial report alleged the SC was dead on arrival when EMS arrived at the home around 12:24 PM on 5/7/17. The SC was found laying on top of the kitchen table facing up while the SF was with her. It was unknown when the SC was last observed alive and by whom. Unknown how the SC died; therefore, the SF was named a subject pending the outcome of the investigation.

The Subsequent report alleged that on 5/7/17 at around 12:10 PM, EMS arrived at the home of the SF, SM and PGM. The SC was in cardiac arrest and had no pulse at the time EMS arrived. CPR was conducted by EMS and the SC was transported to the hospital. The SC died at about 12:50 PM. The SC was observed with blood in her rectum and a healing bruise mark on the body. The SC was otherwise considered healthy but due to the nature of the injuries the death was deemed suspicious.

Executive Summary

The 5-month-old female infant (SC) died on 5/7/17. NYCRO received the ME's report on 10/3/17. The ME listed the cause of death as cardiac arrhythmia in infant with prior cerebral hypoxic event due to perinatal meconium/amniotic fluid aspiration and the manner as natural.

The allegations of the 5/7/17 reports were DOA/Fatality, IG, and II of the SC by the SF, SM and PGM.

ACS findings revealed that on 5/7/17, the SF and PGM (who was visiting the family) were in the home with the SC at the time of the incident. The SM was at work. The SF was supervising the SC in the living room when he observed she was in distress. The SF believed the SC was experiencing difficulty with a bowel movement as she had been using prescribed vitamins due to a medical issue. He utilized a cotton swab in the SC's rectum to aid the bowel movement. The SC had a bowel movement and then stopped breathing. The PGM called 911, and the operator instructed the SF to bring the SC to a flat surface so he brought her to the kitchen table and administered CPR. EMS arrived shortly afterward and transported the SC to the hospital.

ACS learned that the SC had been examined by a medical specialist at Mount Sinai Hospital (MSH) about a month prior to 5/7/17. The Dr. determined that the SC had a medical condition. The SC was given a special formula to address low weight gain concerns. The SC had been using prescribed vitamins. Regarding her medical history, the SC was hospitalized in March 2017 as she had stopped breathing and turned blue. The SC had been eating when she began to gasp for air, 911 was contacted and the SC was transported to the hospital.

ACS provided the parents with a referral for bereavement services and spoke with them about seeking counseling services should they feel the need to speak with a professional. The family declined the referral for services.

On 5/7/17, the PGM contacted ACS. The PGM said she visited the parent’s home on 5/6/17 to babysit. She acknowledged she was in the home on 5/7/17. She had attempted to feed the SC and observed the SC seemed unable to digest the formula. The PGM woke the SF and alerted him about the SC's condition. The PGM went to the bedroom and the SF remained in the living room with the SC. At about noon, the SF observed the SC was not breathing. The PGM told the SF

to attempt to resuscitate the SC, the SF followed her instructions and the SC began breathing. Then the PGM called 911 and they followed the operator's instructions until EMS responded.

On 5/10/17, the Assistant District Attorney (ADA) said there was no suspicion of criminality concerning the SC's death. The ADA explained that the ME's preliminary report exhibited no foul play and the SC's death was most likely due to medical causes.

LE said that the SC's death seemed to be medically related. LE was not actively investigating the parents for criminality.

On 10/2/17, ACS unsubstantiated the allegations of DOA/Fatality, II and IG of the SC by the SF, SM and PGM on the basis that the BF and PGM acted appropriately by contacting 911 and requesting EMS assistance for the SC. The parents had complied with all medical treatment, advice and referrals throughout the SC's life and no child safety concerns were noted by medical providers or relatives to the care the parents provided to the SC. ACS added that the ME completed the autopsy for the SC and listed the cause of death as cardiac arrhythmia in infant with prior cerebral hypoxic event due to perinatal meconium/amniotic fluid aspiration. The manner of death was listed as natural.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
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:
NA

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/07/2017 **Time of Death:** 12:49 PM

Time of fatal incident, if different than time of death: 12:09 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 12:09 PM
Did EMS 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 2
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	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	60 Year(s)

LDSS Response

On 5/7/17, ACS interviewed a nurse (RN) and an attending Dr. The RN said the SF stated that he observed the SC experience difficulty with bowel movement so he applied ointment on the SC's anus with a cotton swab. The SF moved her legs back and forth as a form of exercise. The SC had a bowel movement and then became unresponsive. The SF called 911 and performed CPR as instructed by the operator. The attending Dr. said the SC had developmental delays and failure to thrive. The Dr. said it was suspected that the SC suffered from a medical condition that had not been officially diagnosed. The Dr. said the SC was treated at the hospital on 3/14/17 for a medical condition.

On 5/7/17, the SF was interviewed and he acknowledged he used a cotton swab and exercises to assist the SC with bowel

movement. After he observed the SC was not breathing he told the PGM to call 911.

During follow up interviews with ACS, the SF said the SC was on a set schedule; she had to be fed every 3 hours. The SM said the SC had a tendency to sleep through her feeding schedule, so the parents usually woke her for her feeding. The parents described her motor skills and energy level as "low." The doctors at MSH had instructed the parents to feed the SC every 3 hours, explaining that her weight was low. The Dr. completed a test to evaluate the SC's condition and the results had been pending.

ACS learned that the SC was examined by a medical specialist at MSH about a month prior to 5/7/17. The Dr. determined that the SC had a medical condition. On 5/9/17, ACS verified that the SC was a patient of a clinic and the clinic staff was aware the SC passed away. The staff said the parents followed up as needed.

ACS interviewed a family Dr. who said the SC had pre-existing medical conditions since birth. According to the Dr.'s account, the SC's death, though sudden, was an expected outcome given the SC's medical history. Regarding the initial hospitalizations and visits, the SC was discharged with referrals for Early Intervention (EI) services. At the age of four months, the SC had not been developing on target. The Dr. did not have suspicions about the parents as they were available for appointments. The SC had numerous appointments, the parents accompanied the SC, they were accommodating, and followed up with referrals as recommended. The Dr. did not believe the parents or medical professionals' actions had contributed to the SC's death.

The Dr. from MSH said the SC did not have a confirmed diagnosis prior to her death. The SC was undergoing medical testing, but the official results had been pending. The parents brought the SC in for the scheduled appointments and complied with management. The Dr. last saw the SC on 4/26/17. The Dr. did not have concerns regarding the care the parents provided the SC. The Dr. said there were no concerns of abuse/maltreatment of the SC; the parents followed up with everything including giving the SC her vitamins and bringing her to each appointment. The Dr. explained that there were concerns about the SC's weight gain for which he made a referral for the SC to be examined by a medical specialist.

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: 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 investigations.

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 NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
040801 - Deceased Child, Female, 5 Mons	040804 - Grandparent, Female, 60 Year(s)	DOA / Fatality	Unsubstantiated
040801 - Deceased Child, Female, 5 Mons	040802 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated

040801 - Deceased Child, Female, 5 Mons	040804 - Grandparent, Female, 60 Year(s)	Internal Injuries	Unsubstantiated
040801 - Deceased Child, Female, 5 Mons	040804 - Grandparent, Female, 60 Year(s)	Inadequate Guardianship	Unsubstantiated
040801 - Deceased Child, Female, 5 Mons	040802 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
040801 - Deceased Child, Female, 5 Mons	040803 - Father, Male, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
040801 - Deceased Child, Female, 5 Mons	040802 - Mother, Female, 22 Year(s)	Internal Injuries	Unsubstantiated
040801 - Deceased Child, Female, 5 Mons	040803 - Father, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
040801 - Deceased Child, Female, 5 Mons	040803 - Father, Male, 25 Year(s)	Internal Injuries	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:

The PGM was interviewed by telephone.

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 Unavailable	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	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents declined bereavement counseling.

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

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 parents and PGM were not known to the SCR or ACS.

Known CPS History Outside of NYS

There was no known history outside of NYS.

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