Child Fatality Report

Report Identification Number: NY-18-046

Prepared by: New York City Regional Office

Issue Date: Oct 23, 2018

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: 2 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 05/11/2018
Initial Date OCFS Notified: 05/11/2018

Presenting Information

On 5/10/18, the SC was released from the hospital following a cardiac catheterization procedure. She was in stable condition at the time of discharge. On 5/11/18, the SC was playing with her sibling when she stopped breathing and turned blue. The BM began CPR and called 911. EMS responded and transported the SC to Lincoln Hospital where the SC was pronounced dead at 2:41 AM. The report named the parents as subjects because the SC was stable when she was released from the hospital and she was in the parents' care at the time of the incident.

Executive Summary

The SCR registered a report regarding the death of a two-year-old female that occurred on 5/11/18. The allegations of the report were DOA/Fatality and IG of the SC by the parents. The report named the parents as subjects because the SC was stable when she was released from the hospital and she was in the care of the parents at the time of the incident.

Following the receipt of the report, ACS' Bronx Field Office Specialist contacted Lincoln Hospital (LH) and obtained information regarding the incident. ACS learned the SC was born prematurely, at 26 weeks of gestation and was diagnosed with pulmonary hypertension (PH) and heart disease. On 5/10/18, at 8:00 AM, at Columbia Presbyterian hospital she had a major surgery; she was discharged at 3:00 PM; however, she was not sent home until approximately 5:30 PM due to observation. According to the Dr., the BM reported that the SC was well until 12:00 PM on 5/11/18, when she was given her medication and milk; she stopped breathing and appeared blue in color. The SM called 911 and an ambulance transported the SC to LH where the SC was pronounced dead at 2:41 AM. There was a three-year-old SS in the home at the time of the incident. The SS was in the care of the MGM while the parents were at the hospital. On 5/14/18, ACS assessed the SS and she was deemed to be safe and remained in the parents' care.

On 5/11/18, ACS learned from LE, EMS and the ME that the SC was found with no signs of maltreatment or abuse. According to LE, they found no criminality; it appeared the SC’s death was due to medical complications. The parents confirmed the reported information.

On 5/11/18, ACS learned from the attending physician (AP) at LH that the SC arrived at the hospital via EMS at 12:59 AM, unresponsive. The AP reported the SC could not be resuscitated because of her heart condition.

On 5/14/18, ACS received information from the SC’s cardiologist at Columbia Presbyterian Hospital (CPH) who confirmed the SC’s diagnosis and explained the procedure that was recently performed. The Dr added that the SC’s death was not caused by any “wrong doing” by the parents or the doctors as the SC was a “sick child.”

On the same date, ACS learned from the surgeon who performed the procedure on the SC that the SC’s pulmonary hypertension was "very severe.” Post-surgery, the SC was prescribed oxygen and the visiting nurse agreed to assist. The surgeon stated there were no reported issues on the day of the procedure and no concerns for the SC’s safety; both parents took good care of the SC. The SC was observed to be free of marks or bruises and was always clean and appropriately dressed.

ACS reported the parents were meeting the basic needs of the SS as she appeared well cared for with no safety concerns. ACS referred the family to Association to Benefit Children agency for PPRS services.

On 8/12/18, ACS unsubstantiated all allegations against both parents. ACS cited no credible evidence was found to indicate that either parent caused the SC's death through actions or inactions in seeking medical care and attention for the SC.

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:
The investigation contained collateral contacts with medical providers who explained the child's medically fragile condition and there were no safety concerns for the SS.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	Although the Specialist completed the initial S/A on 5/11/18, it was not approved until 5/17/18.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/11/2018 **Time of Death:** 02:41 AM

Time of fatal incident, if different than time of death: 12:00 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 01:30 AM
Did EMS 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
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	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

On 5/11/18, ACS responded to the report registered by the SCR regarding the death of the two-year-old female by contacting LH to obtain information. ACS also obtained information from LE, ME, EMS and the Specialist interviewed the parents. ACS assessed the SS at the MGM's home and deemed her safe, and she was later returned home with her parents. The allegations of the report were DOA/Fatality and IG of the SC by the parents.

The attending physician in the ER at Lincoln Hospital reported efforts to resuscitate the SC were unsuccessful. ACS documented the physician stated there were no indications of neglect observed on the SC.

The BM informed the Specialist that the SC was born at twenty-six weeks of gestation and remained hospitalized for eight months; she was again hospitalized for one year. The SC was diagnosed with bronchopulmonary dysplasia and heart disease and there were concerns regarding the longevity of the child's life. On 5/10/18, the SC underwent surgery at

Columbia Presbyterian Hospital. Following the surgery, a visiting nurse traveled home with the SC and stayed until approximately 7:30 PM. The SC's pulse was reported to be good when the nurse left. According to the SM, the SC slept a while then played with her sister and appeared normal. The SM also stated the SC was given medication just before bedtime at 12:00AM an hour later at approximately 1:00AM, the SC held her chest as if in pain and her lips appeared blue in color. When the SM checked, the SC's oxygen level had dropped drastically. The SM summoned 911 and attempted CPR until EMS arrived. The SC was pronounced dead at 2:41AM.

The SF was interviewed by ACS on 5/11/18 and he reported that before 12:00AM, he placed the SC in her crib to sleep and attempted to administer oxygen; however, the SC pulled the mask off and after she fell asleep, he administered it. The SF stated he left the home at 1:15AM for his job; he received a call from the SM asking him to return home because the SC was having difficulty breathing. EMS was summoned at 1:30 AM. LE found no criminality and closed their case. The ME reported the final autopsy was pending.

The SC's cardiologist reported the SC was diagnosed with bronchopulmonary dysplasia and she had cardiac disease due to pulmonary hypertension. The SM was compliant with visits and instructions. The surgeon who performed the procedure reported that the parents did nothing that contributed to the SC's death and they had no concerns regarding the care of the children. Both stated she was a "very sick" child.

On 5/16/18, the Specialist received information from the medical provider and neighbor who stated the family always appeared happy and the children were always clean and well cared for with no indications of neglect.

On 5/17/18, the Specialist interviewed the nurse who went home with the family after the surgery and she explained that she had instructed both parents to look for signs that would indicate when emergency medical assistance may be required. She admitted she was worried when she left the home although the SC was stable, because the SC's oxygen levels had been fluctuating. She stated both parents were attentive and loving to the children.

Between 5/18/18 and 8/11/18, ACS continued to visit the home and make collateral contacts and assess the SS. The parents initially accepted, then later declined, services. ACS provided the parents with information for community based services.

On 8/12/18, ACS unsubstantiated all allegations against both parents. ACS cited no credible evidence was found to indicate that either parent caused the SC's death through actions or inactions in seeking medical care and attention for the SC.

Official Manner and Cause of Death

Official Manner: Pending
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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046326 - Deceased Child, Female, 2 Yrs	046327 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
046326 - Deceased Child, Female, 2 Yrs	046328 - Father, Male, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
046326 - Deceased Child, Female, 2 Yrs	046327 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
046326 - Deceased Child, Female, 2 Yrs	046328 - Father, Male, 32 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 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	☒	☐	☐	☐
Explain: The parents declined services.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The SS was deemed safe in the care of the parents.				

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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents received a referral for day care for the 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? Yes

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 known CPS history.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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