Child Fatality Report

Report Identification Number: NY-18-119

Prepared by: New York City Regional Office

Issue Date: May 16, 2019

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: 1 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 11/15/2018
Initial Date OCFS Notified: 11/15/2018

Presenting Information

On 11/15/18, at 8:30 A.M. the SC was transported to Elmhurst Hospital by EMS accompanied by the mother for cardiac arrest. The report alleged mother fell asleep and when she woke up, she noticed the SC was pale and was not breathing. The MGPs were at the house and called EMS who instructed them to do CPR. The SC was unresponsive when the EMS arrived at the home at 8:10 A.M. There was no explanation for the cause of death at the time.

Executive Summary

The SC was one-year-old when he died on 11/15/18. The ME's verbal report of the cause of death was laryngotracheobronchitis from influenza virus II (croup) and the manner of death natural.

The SC resided with his mother, MGPs, MUs and other unrelated persons who rented two rooms in the PGPs home. The home consisted of 5-bedrooms and the mother shared a room with the SC. The SC's father was detained out of state awaiting deportation; ACS confirmed this information.

On 11/15/18, the SCR registered a report with allegations of DOA/FATL and IG of the SC by the mother.

According to the mother and the MGM, on 11/13/18, the MGM cared for the SC throughout the day and noticed he was wheezing and having difficulty breathing. When the mother returned from work at about 6:30 P.M. she gave the SC over-the-counter medication, but his condition did not improve. Therefore, later in evening the SC was taken to the ER where he was diagnosed with croup, and was treated with medication. No medication was prescribed upon discharge as the condition was expected to improve in a couple of days. The mother arrived at the home at 8:00 A.M. on 11/14/18. The mother reported medical staff recommended that if the SC continued to have difficulty breathing, she should sit by a window to give the SC fresh air or use the shower to have him inhale steam. The SC's condition returned and the mother applied these recommendations; however, on 11/15/18 she woke up at 7:00 A.M. to find the SC unresponsive. The SC was found in a siting position in his stroller where, about two hours earlier, the mother had placed him to watch television. The mother and family members called 911 and administered CPR to no avail. EMS arrived and transported the SC to the hospital where he was pronounced dead.

ACS conducted a thorough investigation with clear and concise directives. The investigation was initiated and completed within the required time frames.

On 11/16/18, ACS, the NYPD detective, ME, and the ADA conducted an interview with all the family members. The mother provided a demonstration of the events leading to the SC's death and there was no discrepancy. The NYPD found no criminality surrounding the SC's death; therefore, no arrest was made.

A home assessment was completed and the home was found to be adequate, but there was a need for window guards and a carbon monoxide detector. Both were installed prior to the determination of the report. There was a 2-year-old MU who was assessed to be safe in the care of his parents.

ACS made relevant contact with the medical staff, and the ME who determined there was no sign of abuse or maltreatment on the SC's body. ACS also followed up with the information provided by the mother and confirmed the SC had been treated at the ER prior to his death. Also, ACS interviewed family members and service providers; and none had

concerns about the mother's ability to care for the SC.

On 12/28/18, ACS unsubstantiated the allegations of the report based on the ME's verbal report, which determined the SC's manner of death was natural.

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

Explain:
The level of casework activity was commensurate with appropriate and relevant statutory or regulatory requirements. There was evidence of supervisory consultation and directives. The decision to unfound the report was appropriate.

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:
N/A

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

Child Fatality Report

Date of Death: 11/15/2018 **Time of Death:** 08:27 AM

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

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 07:53 AM
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
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ Other:

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	No Role	Male	2 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	41 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	19 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	17 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	36 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	19 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)

LDSS Response

According to the head nurse at Elmhurst Hospital the SC arrived at the ER via ambulatory transport and was DOA.

Resuscitation procedures were performed on the SC to no avail. The nurse stated the SC was observed to pale and felt cold upon arrival. The nurse indicated the SC had two days of coughing and was taken to NY Hospital when he began to have difficulty breathing. The SC was treated with Albuterol, and nebulizer steroid treatment; he was diagnosed with croup. The nurse confirmed it was normal for doctors to recommend for the parent to have a child near cold air from an open window or use hot steam as this would decrease the swelling to the SC's neck and allow better airflow for breathing. The nurse indicated the SC had no suspicious marks or bruises on his body. ACS later contacted the hospital where the SC was treated prior to his death and confirmed the SC was seen at 12:00 A.M. on 11/14/18 and discharged at 7:25 A.M. The treatment recommendations provided to the mother were confirmed and she appeared to understand the instructions provided.

ACS conducted thorough interviews of events leading to the SC's death, which included a walk through of the case address with the NYPD and the ME. The mother demonstrated the position she placed the SC in the stroller and noted there was a blanket under the SC. The NYPD and the ME were present and did not note any discrepancy.

According to the mother, on 11/15/18 the SC woke up at 12:00 A.M. and his wheezing had worsened; therefore, she held him with his head on her shoulder and sat by a slightly opened window. The mother stated at about 1:00 A.M. the SC appeared to be feeling better as he was awake and active until 4:00 A.M. or 5:00 A.M. The mother said she decided to place the SC in the stroller to watch television in an "upright position to prevent further congestion". The mother said she laid down on her bed and woke up at 7:30 A.M in a panic because she was late for work. The mother said when she took the SC out of the stroller, he was unresponsive, pale and limp. The mother said she ran out of her room to call for help and met the MGF in the living room; he brought the SC back to the bedroom to administer CPR, but the SC did not regain consciousness so she told the MGM to call 911. The MGF, who was not trained in CPR, but had seen videos began chest compressions.

The MGM stated she usually cared for the SC while the mother was at work and on 11/12/18, the SC was "a bit under the weather" and was coughing lightly. The mother, who felt the SC might have caught a cold, gave the SC over-the counter-medicine and it seemed he was feeling better. On 11/13/18, the MGM cared for the SC and she noticed the coughing was progressively getting worse. The MGM said the mother arrived from work at 6:30 P.M. and gave the SC over-the-counter medicine. The MGM said the coughing did not improve, so the mother took him to the ER and returned at 8:00 A.M. on 11/14/18. The mother said the SC was diagnosed with croup and was not prescribed any medication. The MGM said the mother constantly checked the SC; however, in the evening the SC's coughing and wheezing worsened. The MGM said the mother followed the recommendations given by the hospital staff and at about 10:30 P.M., the mother told her the SC seemed to be feeling better. The MGM said on 11/15/18, she was up preparing breakfast when the mother entered the kitchen holding the SC and told her to call 911. The MGM said the SC was pale and limp and she could hear him wheezing; his eyes were slightly open, but "rolled to the back of his head". Due to a language barrier, the MGM gave the telephone to the mother then placed the SC on the table and followed the operator's instruction as interpreted by the mother. The MU and the MGF were also present and participated in the resuscitation efforts. All family members were interviewed and gave consistent accounts.

The report was unfounded.

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 investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048390 - Deceased Child, Male, 1 Yrs	049921 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
048390 - Deceased Child, Male, 1 Yrs	049921 - Mother, Female, 25 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?	☒	☐	☐	☐
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 mother accepted the referral for the bereavement counseling.				

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?	☐	☒	☐	☐

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Window guards and a carbon monoxide detector							

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?	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

The family had no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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