Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-030

Prepared by: New York City Regional Office

Issue Date: Sep 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: 11 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 03/22/2019
Initial Date OCFS Notified: 03/22/2019

Presenting Information

The 3/22/19 SCR report alleged the SM and SF placed the SC in the bed with them during the night on 3/21/19 because the SC was coughing and they wanted to monitor him. At an unknown time, the SM and SF gave the SC Tylenol for his cough. The SM and SF were awake at 2:00 AM and they observed the SC was fine. At 8:00 AM, the SM and SF observed the SC not breathing and the SM called 911. The medical personnel attempted CPR and then transported the SC to the hospital where he was pronounced dead. The cause of death was unknown. The SC was otherwise healthy.

Executive Summary

The 11-month-old male infant died on 3/22/19. The ME listed the cause of death as acute viral bronchiolitis with hypersensitivity reaction and the manner as natural.

The allegations of the 3/22/19 report were DOA/Fatality and IG of the SC by the SM, SF and paternal grand aunt (PGA).

ACS findings reflected on 3/22/19, at about 12:30 AM, the SF reportedly gave the SC Tylenol in the dosage listed on the bottle. The SF placed the SC in a face up position in the parents' twin-size bed to sleep. The SF checked the SC at about 3:45 AM, and observed he was asleep and breathing. At about 8:00 AM, the SF observed the SC was not breathing. The SF woke the SM who contacted 911. At the directives of 911 the SF performed CPR on the SC; however, resuscitation attempts were unsuccessful. EMS responded to the home and transported the SC to the local hospital where he arrived at approximately 8:30 AM. The SC was pronounced dead at 8:58 AM.

During ACS investigation, the SF and SM provided a detailed account of the SC's developmental status, sleep pattern, sleeping arrangement, health, interaction with parents and activities of 3/21/19 and 3/22/19. The SF said the SC slept alongside them in their bed for about three weeks prior to 3/22/19. The SF explained that the paternal aunt's "vaporizer" was filled with water for the SC to treat his wheezing and coughing. ACS did not observe the vaporizer because the SM and SF reported that it was returned to the PGA. ACS interviewed the PGA but did not ask her about the vaporizer.

ACS learned that the SM was unaware the SF administered medication to the SC to alleviate the SC's coughing and wheezing. The SM reported that when she arrived home the SC was not coughing and the SF did not report the SC was ill on 3/21/19. The SM denied the SC had ever been given Tylenol. ACS addressed the SC's sleeping arrangements and the SM said the SC co-slept with them on occasions. ACS found that the family discarded the SC's portable pack and play or crib and the Tylenol medication.

On 7/12/19, ACS unsubstantiated the allegation of DOA/Fatality and IG of the SC by the SM, SF and PGA on the basis of no credible evidence to support the allegations. The ME completed the autopsy and the cause of death was listed as acute viral (Rhino Virus/Entero Virus) bronchiolitis hypersensitivity reaction and the manner of death as natural. There was no evidence to suggest the caretakers' actions or inactions caused the death of the SC.

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:
Sufficient Information was gathered to make a determination for all the allegations.

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:
ACS gathered sufficient information from the attending physician, LE, extended family members, service providers, and neighbors. ACS did not obtain pertinent information from the SC's physician.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Progress Notes
Summary:	The investigation progress notes were not entered contemporaneously. A progress note had an event date of 5/15/19 and an entry date of 7/11/19.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS attempted contact with the last hospital where the SC was admitted. ACS did not make pertinent collateral contact with the SC's physician who was affiliated with a different hospital.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/22/2019 **Time of Death:** 08:55 AM

Time of fatal incident, if different than time of death: 08:00 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:00 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
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	Deceased Child	Alleged Victim	Male	11 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Adult - Paternal Grand Aunt	Alleged Perpetrator	Female	70 Year(s)

LDSS Response

Between 3/22/19 and 3/26/19, ACS visited the home, conducted face-to-face interview with the SM and SF, and obtained relevant information from law enforcement, attending physician, ME, and a neighbor. ACS obtained and reviewed results of domestic violence records, and early childhood and medical consultations. ACS did not ask the SM and SF about their knowledge of safe sleep practices. ACS addressed the issue of possible drug and alcohol use in the household and the SM

reported that they used alcohol on occasions. ACS verified there were no surviving siblings or other children in the home.

According to the SM and SF's accounts, the SC was last seen alive at 2:00 A.M. on 3/22/19. The SM and SF said the SC was found lying on his side on top of the twin sized mattress with his eyes slightly open, not breathing. The SC slept in the same room and on the same surface as the parents. ACS also learned that the SC was hospitalized for illness about three weeks prior to 3/22/19. At the time of hospital discharge, the SC was not prescribed medication but was prescribed a bulb syringe to remove phlegm via suction.

ACS interviewed the attending physician at the local hospital as well as LE and learned that the SC did not have observable marks/bruises when he was brought to the local hospital.

ACS contacted the ME who said the preliminary investigative findings showed there were no obvious signs of trauma on the SC's body. The SM and SF were forthcoming with information related to the SC's death and the information appeared consistent.

On 3/25/19, ACS obtained medical and mental health consultations to discuss the SC's medical condition and the family's support system and strengths. The medical consultation noted the SF gave the SC Tylenol for teething and used a paternal aunt's nebulizer on the SC. The consultant recommended bereavement services and ACS identified relevant community based organizations. The medical consultant recommended that the family be referred to bereavement counseling.

On 3/25/19, ACS contacted a neighbor who reported no concerns regarding the safety/care of the SC and no suspicious activities.

On 3/26/19, ACS offered the SM and SF burial assistance; however, they declined the service and reported that the SC's funeral was scheduled for 4/17/19.

On 3/28/19, ACS interviewed medical providers from the two local hospitals and requested the SC's medical records. ACS Specialist met with the Investigative Consultant and verified there were no domestic incidents involving the SM and SF.

On 5/14/19, ACS followed up with the ME and received the final cause of death. The ME confirmed there were no signs of trauma to the SC's body.

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

Child Fatality Report

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051186 - Deceased Child, Male, 11 Mons	051187 - Father, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
051186 - Deceased Child, Male, 11 Mons	051188 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
051186 - Deceased Child, Male, 11 Mons	051189 - Other Adult - Paternal Grand Aunt, Female, 70 Year(s)	Inadequate Guardianship	Unsubstantiated
051186 - Deceased Child, Male, 11 Mons	051188 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
051186 - Deceased Child, Male, 11 Mons	051189 - Other Adult - Paternal Grand Aunt, Female, 70 Year(s)	DOA / Fatality	Unsubstantiated
051186 - Deceased Child, Male, 11 Mons	051187 - Father, Male, 28 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 progress notes were not entered contemporaneously.

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	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 SM and SF were referred community based services.

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 children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
ACS provided the SM and SF with bereavement counseling and offered burial assistance.

History Prior to the Fatality

Child Information

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

There was no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no CPS History outside of New York State.

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