Child Fatality Report

Report Identification Number: AL-16-026

Prepared by: New York State Office of Children & Family Services

Issue Date: Feb 16, 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	

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	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-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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Rensselaer
Gender: Male
Date of Death: 09/10/2016
Initial Date OCFS Notified: 09/12/2016

Presenting Information

On 9/10/16, the mother and father delayed seeking immediate medical attention for SC, aged 6 months. On 9/10/16, SC woke up from a nap at 3pm with labored breathing and was acting suspicious. Sometime after, SC's temperature was 101.4 degrees and his breathing continued to deteriorate and he began turning a bluish purple color. As a result of the parents' delay in seeking medical care, the SC went into cardiac arrest. EMS transported the SC to the hospital where staffed worked on him for a long period of time before they were able to a get a pulse and resuscitate him. At 8:23pm on 9/10/16, the SC died while inpatient in the intensive care unit.
The SC was born with Chromosomal issues, however, it is unknown if that is the cause of the SC going into cardiac arrest today. From the time the parents stated SC awoke from his nap, 3pm, to the time of the call to EMS (about 4:40pm) was approximately 1 hour and 40 minutes.

Executive Summary

On 9/10/16, an SCR report was received with allegations of Lack of Medical Care and Inadequate Guardianship against the mother and the father of the subject child. The SC woke from a nap around 3pm with labored breathing, a fever and turning blue. The parents did not call 911 until 4:40pm. The SC was in cardiac arrest.

Later that day, on 9/10/16, the SC passed away at 8:23pm.

The 6 month old SC was born with a chromosomal abnormality and also had a traumatic birth with the umbilical cord being wrapped around his neck and two vessel cords. The SC had multiple disabilities, vision and hearing impairment, was fed through a feeding tube and had been having seizures since birth. The SC was under the care of a team of medical professionals, as well as, in home speech, physical therapy, occupational therapy, and early intervention. The SC was born to young parents who up until the summer of 2016, lived with the maternal grandparents. At that time, the mother, father and SC moved into their own apartment. The SC was on 7 medications, one of which was an anti-seizure medication. This medication ran out on 9/2/16, however, they parents stated the script could not be filled by the insurance company until 9/4/16. The parents did not have transportation to pick up the medication from the pharmacy until 9/9/16. The father had a vehicle that he had been driving, however, it broke down. The parents typically asked the maternal Aunt or grandmother for assistance in the past but the mother did not want to ask her family for help. On 9/9/16, the parents asked the maternal grandmother to pick up the medication, which she did.

The investigation revealed that the SC was very ill and had a problem with every organ system in his body. The parents appeared to be doing their best managing the doctor's appointments and needs of their child. They had a team of medical professionals and working with a Palliative care team JOURNEY's. The investigation revealed there was an 8-9 day period of time where the SC did not have his anti-seizure medication. The Medical Examiner and doctors could not conclusively say that this caused the SC's death, however, it could have contributed to the child having a seizure and then to his death. The preliminary autopsy findings were Natural manner of death and Cause was seizure disorder due to anoxic- ischemic encephalopathy.

The determination was made to indicate the allegations of Lack of Medical Care and IG against both parents. The

parents had resources they could have used to assist them in picking up the prescription medication. However, they did not use those resources or ask for help until 8 to 9 days later. On the day the child stopping breathing, 9/10/16, there was a delay in seeking medical treatment. The SC was found unresponsive at 3pm and the 911 call did not take place until 4:40pm. The parents did not have an explanation for the delay in the call. There were no other children in the home. The mother is pregnant and the CW made a referral to Healthy Families. The mother is attending all pre natal appointments. It is unclear whether or not the new baby will have chromosomal abnormalities.

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?** 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 casework activity during the investigation 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:
The decision to indicate all allegations and close the case on 11/22/16 was appropriate.

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: 09/10/2016 **Time of Death:** 08:23 PM

Time of fatal incident, if different than time of death: 03:00 PM

County where fatality incident occurred: RENSSELAER

Was 911 or local emergency number called? Yes
Time of Call: 04:40 PM
Did EMS to 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 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	6 Month(s)
Deceased Child's Household	Father	No Role	Male	21 Year(s)
Deceased Child's Household	Mother	No Role	Female	19 Year(s)

LDSS Response

Upon receipt of the SCR report on 9/10/16, LDSS immediately began a joint investigation. LDSS on-call CW spoke to the source and responded to the hospital. Then with LE, began interviewing the family and collaterals. Later that day, LDSS became aware that the SC had passed away. The interview of the parents revealed that the SC had a chromosomal abnormality and a traumatic birth where the umbilical cord was wrapped around his neck and two vessel cords. The SC spent 3 months in the NICU and had a visiting nurse, physical therapy, speech therapy, early intervention, and had 11 doctors including the primary care and specialty doctors. The SC was on 7 medications and had a feeding tube. The SC also had seizures since birth. The BM reported running out of seizure medication on 9/2/16. The script could not be filled until 9/4/15 due to insurance and due to lack of transportation, they did not pick up the medication until 9/9/16. BM goes on to say that on 9/8/16 the SC woke up at 7am, was given his seizure medication at 8:45am and BM left for work. BM returned home at 2:15pm and reported no concerns. On 9/9/16, BM, BF and SC were picked up by MGM around 5pm and stayed overnight at her house. The SC was fed and received seizure medication at 11pm at the last feeding. On 9/10/16, they returned to their own house around 11am. BM, BF, and SC laid down for a nap at 12 or 12:30pm and woke around 3pm. BF noticed SC wide awake in crib and placed SC in bed with BM around 3:30pm. BM immediately noticed SC not moving around as usual and brought SC out to BF in living room. They checked SC's reaction to a flashlight and sunlight, he did not react. SC’s temperature was 101.4. SC then began to defecate thin white stool, threw up and stopped breathing. BF performed CPR while MO called 911. The call to 911 did not take place until 4:40pm.

The timeline of events reported by the BF was generally the same. However, the BF reported that they ran out of the seizure medication on 7/30/16 and that the insurance would not cover the medication until 9/4. The parents contacted their medical team who helped them get the prescription filled. The BF said the medication was picked up on 9/9/16.

The MGM reported being unaware that the SC was out of medication, however, when asked on 9/9/16 to pick up the prescription, she did it that day. The MGM received a call from the BM at 4:35 asking to use her car to take the SC to the hospital. By the time she got to the house, the SC was already transported via ambulance to the hospital.

At investigation conclusion, it was still unclear the exact number of days the SC was without medication, however, it was concluded to be 8 or 9 days based on all interviews and collateral contacts.

LDSS conducted collateral interviews with the SC's in home therapy providers, no concerns were noted. The CW confirmed with Pediatric Neurologist that the child was last seen on 8/17/16 and the anti seizure medication was prescribed on 8/26/16. The doctor reported the SC not having medication for 8-9 days could lead to the SC having a seizure which could lead to fatality. LE decided to close their case with no criminal charges after finding out on 9/12/16, the preliminary cause of death was seizure disorder due to anoxic-ischemic encephalopathy.

LDSS notified OCFS and the CFRT and conducted a thorough investigation. LDSS concluded that the BF and BM had resources they could have accessed in order to get the SC his medication. In addition, there is no explaination for the 1hr 40 min delay in making the 911 call as the SC had a fever and was demonstrating other concerning symptoms.

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 reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The case was reviewed on 10/5/16.

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?	☒	☐	☐	☐

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:
LDSS completed a thorough investigation and documented in a timely manner

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 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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Referral to Healthy Families

Additional information, if necessary:
The family was referred to Healthy Families as mom is pregnant and due in March 2017. It is unclear if the new baby will have chromosomal abnormalities as well.

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:
No other children

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
A referral was made for the parents to Community Hospice regarding grief counseling. The parents were referred to Healthy Families regarding mom's current pregnancy.

History Prior to the Fatality

Child Information

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

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 fetal alcohol effects or syndrome

☒ With neither of the issues listed noted in case record

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)
09/10/2016	12893 - Deceased Child, Male, 6 Months	12892 - Father, Male, 21 Years	Lack of Medical Care	Indicated	No
	12893 - Deceased Child, Male, 6 Months	12894 - Mother, Female, 19 Years	Lack of Medical Care	Indicated	
	12893 - Deceased Child, Male, 6 Months	12892 - Father, Male, 21 Years	Inadequate Guardianship	Indicated	
	12893 - Deceased Child, Male, 6 Months	12894 - Mother, Female, 19 Years	Inadequate Guardianship	Indicated	

Report Summary:
On 9/10/16, SC woke up at 3pm with labored breathing and was acting suspicious. Sometime after, SC's temperature was 101.4 degrees,his breathing deteriorated and he began turning a bluish purple color. EMS transported the SC to the hospital where staffed worked on him for a long period of time before they were able to resuscitate him. The SC was born with Chromosomal issues, however, it is unknown if that is the cause of the SC going into cardiac arrest. From the time the parents stated SC awokefrom his nap,3pm, to the time of the call to EMS (about 4:40pm) was approximately 1 hour and 40 minutes. The BM and BF delayed seeking immediate medical attention for SC.

Determination: Indicated | **Date of Determination:** 11/22/2016

Basis for Determination:
The investigation revealed that the parents failed to pick up the SC's prescription for anti seizure medication, leaving the SC without medication for 8 to 9 days. The SC's doctors and the ME explained that the lack of medication could have caused the seizure which then may have caused and/or contributed to the SC's death. The allegation of IG is indicated as the parents failed to meet a minimum standard of care for their child. The allegation of LMC is indicated as both parents failed to provide adequate medical care despite being able to do so. The parents also did not call 911 in a timely manner when SC was displaying seizure like behavior. All allegations IND and closed on 11/22/16.

OCFS Review Results:
No concerns with the investigation and in agreement with case determination.

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

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

The MO was listed as the MA/AB child on several SCR reports. On 10/8/09 an SCR report was received with allegations of IFSC and IG regarding BM, then age 12yo, against her mother and father. The report alleged IFSC and IG regarding her siblings then ages 17, 15, 12,9,7 and 2 mos against both parents and allegations of LMC for the 15 yo sibling against both parents. On 12/16/09 all allegations listed on the report were UNF and the case was closed.

On 1/14/11, an SCR report was received with allegations of EdN against the mother (SC's MGM) regarding her then 16 yo child. Other children in the home ages 13, 10 and 8 were listed with unk roles. This case was tracked FAR and the FLAG identified the need of the 16 yo to go to school. The school and family made a plan for the child to attend tutoring. The case was closed on 3/10/11.

On 5/30/11, an SCR report was received with allegations of CD/A, IG and LS against the mother for the 16 y/o and the BM (then 13y/o). Allegations were also listed of IG and LS against the mother regarding the 10, 8 and 2 yr old children. The case alleged mom was leaving the children with caregivers who were using drugs. The case was tracked FAR. No FLAG needs were identified. The case was closed on 7/28/11.

On 8/6/12, an SCR report was received with allegations of IFCS and IG against the mother and her 18yo son regarding her other children ages 15, 12, 9, 3, and 1. The case was tracked FAR, no needs were identified. The case was closed on 11/14/12.

Known CPS History Outside of NYS

No known history outside of NYS.

Required Action(s)

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

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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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? 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