Child Fatality Report

Report Identification Number: AL-18-022

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

Issue Date: Feb 19, 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 | **Jurisdiction:** Washington | **Date of Death:** 09/15/2018
Age: 5 year(s) | **Gender:** Male | **Initial Date OCFS Notified:** 09/17/2018

Presenting Information

An SCR report received 9/15/18 alleged that while the child was riding his bicycle with his siblings and another child he flipped over the handlebars of the bicycle and sustained an abrasion to his shoulder. The incident occurred at 6:00PM and at 7:00PM, he was having difficulty breathing and complained of abdominal pain. The parents contacted a doctor, who came to the home immediately. The doctor recommended emergency medical attention, which the parents did not follow. The child vomited 6 times that evening, developed a fever and made incoherent statements. The child slept in the bed with the parents. The father left the home at 2:00AM on 9/16/18. When the mother awoke, she noticed the child's limbs were cold, but believed he was sleeping comfortably. At 7:00AM, she found the child deceased. The mother called the father and he called a funeral home. The funeral home notified authorities. The child had no known medical conditions prior to the accident.

Executive Summary

This fatality report concerns the death of the 5-year-old male child who died on 09/15/18. A report was made to the SCR on the same day regarding concerns the parents did not seek medical attention for the child after he was involved in a bicycle accident the day prior; however, investigation revealed that the parents received medical advice from a doctor who performed an assessment on the child.

Washington County Department of Social Services (WCDSS) coordinated efforts with law enforcement upon the receipt of the SCR report. The family had no criminal history, or any CPS history. Law enforcement took statements from the parents and the doctor, and found no criminality during the investigation. Law enforcement closed the criminal investigation without any charges filed.

During the investigation, several home visits were made and the family was interviewed. There were eight surviving minor children (ages 1, 4, 8, 10, 11, 13, 15, and 17 years) who were assessed to be safe in the care of their parents.

The children and a friend were riding bicycles when someone stopped abruptly in front of the subject child causing him to crash into the other bicycle. He flew over the handlebars and landed on the gravel. The child experienced pain to his abdomen immediately upon impact. The were no known injuries to the other child involved in the accident. The child was reported to be wearing a helmet when he crashed. During investigation, it was learned that prior to the accident, the child was hesitant to eat dinner and was complaining about a stomach ache.

Soon after the accident, the mother contacted a medical doctor, who was a friend of the family, to assess the child at the family’s home. The doctor thought the child experienced blunt force trauma, but found no signs of internal injury. He advised the parents to seek further medical attention if the child’s condition worsened.

As the night progressed, the child continued to feel pain and his symptoms worsened. He vomited several times, was complaining of head pain, was making incoherent statements, and was breathing abnormally. The parents reached out to the doctor, but did not get a timely response and the parents did not take the child for emergency care. The mother slept in the same bed as the child, and when she woke up, she found the child deceased.

911 was contacted and EMS responded. No resuscitation efforts were made and the child was pronounced deceased at the scene. An autopsy was performed and the ME listed the cause of death “severe acute peritonitis due to gastric rupture due

to blunt force trauma” and the manner of death as accident.

The family declined to be connected with any services stating that they have a lot of community support. WCDSS completed required safety assessments and fatality reports; however, although WCDSS completed the assessment with the family, the 24-hour fatality report and 24-hour safety assessment were not completed and approved timely in Connections. Investigation revealed that the parents sought out the advice of a medical professional, who noted no signs of internal injury or a concussion. The mother did not recognize the child's condition worsened because the child did express increased stomach pain or that he was bleeding, which were signs she was looking for. WCDSS determined there was no credible evidence to support the allegations within the report. The report was unfounded and the case was closed.

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? 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 casework activity was thorough and appropriate.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour Fatality Report was completed and approved 1 day late.
Legal Reference:	CPS Program Manual, Chapter 6, K-1

Action:	WCDSS must complete a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available and required in CONNECTIONS for all reports containing an allegation of a child fatality.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour safety assessment was not approved until 1 day after the due date.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	A safety assessment will be completed and approved by a supervisor within 24 hours of a report if such report contains the allegation of DOA/Fatality, as required.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/15/2018 **Time of Death:** 06:46 PM

Date of fatal incident, if different than date of death: 09/14/2018
Time of fatal incident, if different than time of death: 06:00 PM

County where fatality incident occurred: Washington
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	Male	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	46 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Female	17 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)

LDSS Response

On 9/15/18, WCDSS received two SCR reports regarding the death. WCDSS completed a CPS and criminal check, and notified the ME and DA of the death. Upon learning of the death, WCDSS initiated the investigation and coordinated with LE. In addition, WCDSS contacted the state of Missouri, where the family previously resided, and found no history. The eight SS were assessed and safe.

On 9/15/18, WCDSS interviewed the parents, SS and relatives. Around 5:30PM, the family ate dinner; the SC was hesitant to eat and said his stomach hurt. After dinner, the children and a friend rode bikes and the SC crashed into another child's bike. The SC flew over the handlebars and landed face down on the gravel. He screamed and was crying. The SM saw the accident and carried him inside and placed him on the parents' bed. The SC was wearing a helmet at the time of his accident, the 15yo and 17yo SS were working, and the father did not see the accident.

The SC complained of stomach pain and thought he was going to vomit. He was breathing fast and shallow, was opening and closing his eyes and was "talking gibberish". The SM looked at his stomach and saw a red spot, which she did not consider blood or an abrasion. She contacted a doctor to have the SC assessed.

Between 6:30-7:20PM, the doctor assessed the SC at the home, using his hands and a stethoscope. The doctor reported to LE that the SC's stomach was soft and mildly tender "without guarding or rebound" and told the parents to bring the SC to the hospital if his condition worsened. The doctor presumed the SC had blunt force trauma to his abdomen, but did not note any internal injury. The SC was given a hot water bottle to place against his abdomen. The doctor witnessed the SC vomit, which did not appear to have blood in it. The SC also urinated and the urine did not contain visible blood.

The family heard the SC making incoherent statements throughout the evening and said he looked ill, and his breathing remained fast and shallow. The SC said his head hurt, but was no longer crying; however, he stated he was going to die and was holding his side. The SC remained in the parents' bed and slept next to the SM during the night.

Around 9:55PM, the SM contacted the doctor to inform him of the SC's fever, that he vomited several more times, was thirsty and excessively urinating. The parents attributed the symptoms to a stomach virus, as the SC was complaining of a stomach ache prior to the incident. The SM did not receive the doctor's response until 7:40AM on 9/15/18, after she discovered the SC dead. The doctor agreed the SC could have stomach virus and advised small sips of water, ginger and honey to sooth his stomach.

The SF did not sleep with the SM and SC, but heard the SC making bizarre statements around 1:45AM. Around this time, the SM reported the SC's fever was down. She said his belly was warm and his extremities were cool. The SM recalled waking in the night, and realized the SC had quieted down and she could not hear his erratic breaths and thought he was asleep.

Around 7:00AM, the SM discovered the SC was dead. She contacted the SF, who was at work, around 7:20AM, and

notified him of the death. When the SF arrived home, the SC was cold, with stiff limbs. He contacted the funeral home director and notified him of the death. The funeral director contacted 911 and EMS responded. The SC was pronounced dead by the coroner at 6:46PM.

Several home visits were made during the investigation and collaterals were interviewed. Family members, including grandparents and adult siblings, reported no concerns for the safety of the SS.

The family had no CPS history and no criminal history. LE did not file any criminal charges against the parents as a result of the death.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Washington County does not have an OCFS-approved Child Fatality Review Team at this time.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048027 - Deceased Child, Male, 5 Yrs	048028 - Mother, Female, 46 Year(s)	DOA / Fatality	Unsubstantiated
048027 - Deceased Child, Male, 5 Yrs	048028 - Mother, Female, 46 Year(s)	Inadequate Guardianship	Unsubstantiated
048027 - Deceased Child, Male, 5 Yrs	048028 - Mother, Female, 46 Year(s)	Lack of Medical Care	Unsubstantiated
048027 - Deceased Child, Male, 5 Yrs	048029 - Father, Male, 49 Year(s)	DOA / Fatality	Unsubstantiated
048027 - Deceased Child, Male, 5 Yrs	048029 - Father, Male, 49 Year(s)	Inadequate Guardianship	Unsubstantiated
048027 - Deceased Child, Male, 5 Yrs	048029 - Father, Male, 49 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐
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	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
The family was offered grief counseling for the children; however, the parents declined as they had other community supports.

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

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?	No

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 3 years prior to the fatality.

Known CPS History Outside of NYS

There was no known 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