Child Fatality Report

Report Identification Number: NY-16-134

Prepared by: New York City Regional Office

Issue Date: Apr 03, 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: 3 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/16/2016
Initial Date OCFS Notified: 12/17/2016

Presenting Information

On 12/17/16 Preventive service agency, Sauti Yetu Center for African Women and Families notified OCFS of the SC's death. According to the agency's report, the child was born on 8/18/2016; 24 weeks premature. His lungs were not fully developed. He developed a medical condition while in the Neonatal Intensive Care Unit and never left the hospital. On 12/8/16 the infant had surgery to remove air from his lungs. He passed away on 12/16/2016. The child was at Montefiore Hospital in the Bronx.

Executive Summary

The SC was born 26 weeks premature on 8/18/16 with a serious medical health condition. The SC was never discharged from the hospital; he remained there receiving medical treatment up to time of his death. Progress Notes documentation indicated that the SCs medical health condition grew more serious while in the hospital. On 12/8/16, medical staff performed surgery to remove air from his lungs. The hospital medical staff met with the family on 12/12/16 and 12/16/16 to discuss the SC's prognosis and prepare the parents for the infant's death as there was little progress following the surgery. The SC was given comfort care during his last days.

According to the case record, on 9/8/16 the BM walked into preventive services (PPRS) agency, Sauti Yetu Center for African Women and Families, requesting assistance with housing and entitlements.

According to the agency's notification to OCFS received on 12/17/16; the SC died on 12/16/16. The Death Certificate listed the cause of death as Natural.

The PPRS agency, Sauti Yetu, monitored the home and provided the family with casework counseling in their native language; housing assistance; and financial support for the SC's funeral.

Following notification of the SC's death by hospital staff, the Case Planner (CP) contacted the family and conducted a home visit to offer condolences, provide moral support and grief counseling. The CP provided referrals to the Senegalese Association and Islamic International Funeral Service for guidance in securing a proper burial for the infant. Agency staff attended the SC's funeral on 12/22/16.

Cultural sensitivity was practiced by the agency in that the staff effectively communicated with the family in their native language. Additionally, detailed Progress Notes (PN) reflected the conversations and outcome of same, with the family and collateral contacts. The CPs PN documentation presented evidence of good family engagement practice; the family maintained frequent contact with the agency, providing status updates where necessary. The PN showed that the agency provided emotional support as the family grieved the loss of their child.

There were no SS or children living in the home. Therefore, the agency referred the family to a community-based organization for ongoing support, then appropriately closed the preventive services case on 1/7/17.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
N/A

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 case was closed due to the death of the child. There were no surviving children.

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: 12/16/2016 **Time of Death:** 02:09 AM

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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: Intensive Care unit

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
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	No Role	Male	4 Month(s)
Deceased Child's Household	Father	No Role	Male	45 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)

LDSS Response

The preventive agency (Sauti Yetu) forwarded ACS' 24-hour Notification Report and the required OCFS-7065 to the Office of Children and Family Services.

Upon learning of the SC's death, the CP conducted a home visit and offered condolences, support, and grief counseling to the family.

The agency assisted the family by providing financial assistance for funeral arrangements. The agency advocated on the family's behalf with the Senegalese Association and Islamic International Funeral Service that provided additional assistance and support to the family. The CP and supervisor attended the SC's funeral that occurred on 12/22/16.

The SC's death was not reported to the Office of Medical Examiner because the SC died in the hospital; no documentation indicated an autopsy was required or completed on the SC.

The CP appropriately assessed the case for closing and referred the family to a community-based organization for additional support. The PPRS case was closed on 1/7/17.

OCFS determined from interviews with program staff and review of case documentation, that the staff were very knowledgeable of the family's circumstances and status of service plan interventions. The staff empathized with the family during their grieving, and provided useful support to them; a positive indicator of family engagement skill utility.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: N/A

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:
N/A

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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: N/A							

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 SS or other 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:
The agency assisted the family with funeral arrangements, and referrals to the Senegalese Association and the Islamic International Funeral Service. The agency conducted a home visit to provide support and grief counseling.

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

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

Review of the CONNECTIONS child welfare recording system showed there were no SCR reports or CPS involvement for the case family.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS for the case family.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 09/19/2016

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
Preventive services were opened for this family as an ADVOCATE case with Sauti Yetu Center for African Women and Families. The mother requested assistance with housing issues. Also, she was not working at the time, and needed assistance obtaining entitlements (Food Stamps, Medicaid).

Required Action(s)

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

Issue:	Eligibility for Preventive Services
Summary:	The agency inappropriately assessed programmatic eligibility for provision of PPRS by selecting Preventive Non-Mandated. Case circumstances showed eligibility criteria for Mandated Preventive - Child Services Needs.
Legal Reference:	18 NYCRR 423.3 and 430.9
Action:	ACS must submit a corrective action plan to OCFS within 45 days regarding its actions to address the identified issue. ACS must include its policies regarding Programmatic Eligibility and Program Choice for service providers. ACS must ensure that Sauti Yetu meet with staff to address this issue, and inform OCFS of the date of the meeting, who attended, what was discussed, and the action plan.

Preventive Services History

According to the case record, on 9/8/16 the BM walked into preventive services (PPRS) agency, Sauti Yetu Center for African Women and Families, requesting assistance with housing and entitlements. On 9/11/16, the CP conducted an initial visit to the home and engaged the parents. The family signed for, and began receiving PPRS on 9/16/16.

The program choice selected was Preventive Non-Mandated; the PPG was Prevent Placement. However, the agency did not appropriately assess programmatic eligibility for PPRS in that the case circumstances met Programmatic Eligibility criteria of Mandated Preventive. The initial service plan included counseling and housing support for the parents and

monitoring of the SC who was hospitalized since his premature birth. The CP conducted adequate casework contact visits to the home as well as the hospital. The CP maintained contact with medical personnel regarding the SC's prognosis.

On 12/16/16, hospital staff notified Sauti Yetu of the SC's death. The CP appropriately assessed that the case no longer met the standards for preventive services in that there were no SS or children living in the home. Therefore, the CP referred the family to a community based organization to address the family's needs, and the preventive case was closed on 1/7/17.

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