Child Fatality Report

Report Identification Number: NY-18-014

Prepared by: New York City Regional Office

Issue Date: Aug 08, 2018

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: 5 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 02/10/2018
Initial Date OCFS Notified: 02/10/2018

Presenting Information

On 2/10/18, the SCR registered a report alleging the 5-year-old SC died after a short illness. The report also alleged the SC had no pre-existing condition and was an otherwise healthy child. The SC had flu symptoms and a spiked a fever on 2/9/18. The mother attempted to control the fever with a cool bath and Tylenol. The mother left the SC in the tub with the drain open and a few minutes later found the SC slumped over. The mother called 911 and the SC was transported by EMS to the hospital where she was pronounced dead.

Executive Summary

The SC was five years old when she died on 2/10/18. The autopsy report listed the cause of death as respiratory tract infection (influenza A1 H1–2009) and the manner of death as natural.

On 2/10/18, the SCR registered a report concerning the SC's death. The allegations of the report were DOA/Fatality and IG of the SC by the mother. The family had no CPS history prior to the SC's death.

ACS initiated the investigation within the required timeframe and on 2/11/18 and 2/12/18, the mother and sibling were interviewed at the home of a MA where they stayed after the SC's death. ACS assessed the MA's home was safe for the sibling and there were appropriate accommodations for him and the mother. The MA had no concerns about the mother's ability to care for the children.

According to the mother, on 2/9/18, she gave the SC Tylenol and placed her in the bathtub with the drain open and lukewarm water to reduce a fever. The mother walked away and when she returned, she found the SC unresponsive. The 12-year-old sibling was in the home and corroborated the mother's account. The mother called 911; EMS responded to the call and transported the SC to Brookdale Hospital where she was pronounced dead. This account was consistent with the information the mother provided to the NYPD and Brookdale Hospital. The mother said she did not take the SC to the hospital earlier because she thought she could treat the SC at home.

Brookdale Hospital confirmed the SC arrived at the ER at 8:30 P.M. and was pronounced dead at 9:02 P.M. The medical staff stated the SC tested positive for the flu, but noted the ME would determine the cause and manner of death.

The NYPD reported there were no signs of criminality surrounding the death of the SC or concerns about the conditions of the home.

On 3/9/18, as per protocol, ACS held an initial Child Safety Conference (CSC) and found there was no Family Court intervention needed as there were no safety concerns for the SS. Despite their assessment that there were no safety concerns, ACS held another CSC on 4/6/18. ACS insisted the second CSC was necessary to "develop a plan to move forward on this case" in spite of the fact that the parents planned to seek counseling and services through the mother's EAP and the family's church. At the second conference, the mother reiterated the family would deal with the SC's death "in their own way." The family refused services offered by ACS.

ACS took appropriate actions when assessing the safety and risk of the sibling; however, did not properly complete the safety or risk instruments. ACS selected a safety decision that reflected the sibling was in immediate and impending danger of serious harm. The case documentation or the family's circumstances was not consistent with the selected safety

decision.

The father was actively involved with the children and ACS interviewed him throughout the investigation; however, he was not listed as a Secondary Caretaker in the Risk Assessment Profile (RAP) and was not provided with a Notice of Existence.

On 4/10/18, ACS unfounded the report. ACS unsubstantiated the allegations against the mother citing the SC died after a short illness. ACS documented the mother attempted to reduce the SC's fever and contacted 911 to obtain emergency medical care.

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?** No

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 appropriate, but the instruments were approved even though they were not properly completed.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS selected safety decision and safety factors that were not consistent with the case documentation or the family's circumstances.

Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7-day safety assessment was not completed timely. In addition, the selected safety decision and safety factors were not consistent with the case documentation or the family's circumstances.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	ACS did not complete a 30-day safety assessment.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	ACS did not list the children's father as a Secondary Caretaker; therefore did not properly complete the RAP.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The determination safety assessment was not completed properly, as the selected safety decision and the safety factors were not consistent with the case documentation or the family's circumstances.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to provide notice of report
Summary:	ACS did not issue a NOE to the children's father who was a person legally responsible.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.

Child Fatality Report

Summary:	ACS did not complete a 30-Day Fatality Report timely. The SCR report was dated 2/10/18 and ACS approved the 30-Day Report on 4/10/18.
Legal Reference:	CPS Program Manual, VIII, B.2, p.4
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a PIP within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/10/2018 **Time of Death:** 09:02 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:00 PM
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: bath

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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Father	No Role	Male	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)

LDSS Response

ACS initiated the investigation by contacting the NYPD and Brookdale Hospital. The NYPD indicated there was no

criminality found surrounding the SC's death. The medical staff at Brookdale Hospital stated the SC tested positive for the flu and had a fever of 102.7 degrees Fahrenheit. Due to the SC's test result, the sibling was also tested for the flu and his result was negative. There was no sign of abuse or neglect concerning the SC or the sibling.

ACS spoke to a neighbor who expressed the family was "quiet" and there were no concerns about the care of the children.

The parents were temporarily separated and in the process of a reconciliation; therefore, the father was not in the home at the time of the incident. The mother notified the father and he picked up the sibling to stay with him overnight. The father spoke to ACS and escorted the sibling to the MA's home to be interviewed.

According to the mother, the SC went to school on 2/9/18 and returned from school with a dry cough. On 2/10/18, the SC appeared to have a fever. The mother went out of the home at about 8:30 A.M. to get medicine and a thermometer. She returned home and realized she bought an item in error instead of a thermometer. She did not have a thermometer to take the SC's temperature. At about 9:00 A.M., she gave the SC Tylenol and the SC fell asleep. The SC woke up sometime between 11:00 A.M. to 12:00 P.M., and was hungry. The SC ate oatmeal and then laid in bed to watch videos. The mother monitored the SC in the home and sometime between 7:30 P.M. and 8:30 P.M., she found the SC's skin felt hot again. She did not give the SC more Tylenol because it had not been 12 hours since she had given the SC the first dosage. The mother placed the SC in the bathtub with cool water, the SC complained the water was cold and the mother changed the water temperature to lukewarm. The mother said the drain was left open and the SC was playing with her dolls. The mother said she stepped away for about 10 minutes to get a towel and when she returned, the SC was lying on her back unconscious. The mother said she grabbed the SC and ran to the door asking for help because she did not know how to perform CPR. A neighbor performed CPR, but the SC was not responding, so the mother told the sibling to call 911. EMS arrived, attempted resuscitation and transported the SC to hospital where she was pronounced dead. ACS obtained records of the 911 calls and confirmed several calls were recorded with 911, which included the mother, sibling, and neighbors.

The sibling corroborated the mother's account and stated that prior to the incident, he was in his room playing a video. The sibling said he heard the mother scream and proceeded to call 911.

The mother refused to sign a HIPAA form for the sibling and reported the sibling had no medical issues. ACS contacted the NYC Department of Health and confirmed the sibling's immunizations were up to date. No information regarding the SC's immunization was documented.

On 2/12/18, ACS contacted the children's school and confirmed the SC was seen in school on 2/9/18. The social worker stated the SC was not feeling well, but this response was not explored further. There were no concerns reported about the children's attendance, behavior or academic performance. There were no inquiries about the parents' involvement with the school.

On 2/27/18, after the SC's burial, the parents allowed ACS access to their home. ACS found no safety concerns. ACS did not document a detailed description of the home as it pertained to the SC's death. The mother informed ACS the family intended to relocated to another state and she had requested a work transfer from her employer.

On 4/10/18, ACS unfounded the report.

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 NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046567 - Deceased Child, Female, 5 Yrs	046569 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
046567 - Deceased Child, Female, 5 Yrs	046569 - Mother, Female, 34 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?	☐	☒	☐	☐
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 mother refused to sign the HIPAA forms.
The 7-day safety assessment and 30-day fatality report were not completed timely.

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 safety 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?	☐	☐	☒	☐
Explain: The 24-hour and 7-day safety assessments were completed incorrectly as the selected safety decision and the safety factors were not consistent with the family's circumstances. The 7-day safety assessment was not completed timely. ACS did not complete a 30-day safety assessment.				

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 parents chose to seek services via the mother's EAP and their church. ACS did not include the father as a Secondary Caretaker in the RAP although the documentation showed he provided care of the sibling.				

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?	☐	☒	☐	☐
Explain as necessary: N/A				

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:
There were no immediate services needed. Later services were offered, but the parents refused services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There were no immediate services needed. The parents were offered services, but they refused the 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

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

Known CPS History Outside of NYS

The family had 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