Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-116

Prepared by: New York City Regional Office

Issue Date: Mar 25, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 10 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 10/26/2019
Initial Date OCFS Notified: 10/26/2019

Presenting Information

The fatality narrative alleged on 10/25/19, the BM noticed the SC was fussy, experiencing an increase in crying, and had two episodes of vomiting. Between 11:00 PM and 12:00 AM, the BM laid the SC down to sleep in his crib and at 6:00 AM on 10/26/19, she checked on the SC. The SC was fussy at the time but went back to sleep. At 8:30 AM, the parents found the SC in his crib, unresponsive with no pulse. The parents called 911 and EMS responded to the home and found the SC unresponsive and stiff. CPR was performed on the SC while he was being transported to the hospital. When the SC arrived at the hospital, his abdomen was distended. The medical staff continued CPR on the SC; however, he was unable to be revived. The ER Dr. pronounced the SC dead at 9:20 AM. There were no surviving siblings or other children in the home.

Executive Summary

On 10/26/19, the SC passed away in his parents' home due to a medical condition called malrotation which occurred during fetal development. According the ME, the SC's cause of death was Volvulus due to congenital gut malrotation syndrome in infant with history of omphalocele (surgical corrected). The manner of death was natural.

ACS' case documentation reflected on 10/25/19, the SC was fussy, experiencing an increase in crying, and had two episodes of vomiting. Between 11:00 PM and 12:00 AM on 10/26/19, the BM laid the SC down to sleep in his crib and he did not appear to be in distress. At 6:00 AM, the BM checked the SC, he was fussy at the time but went back to sleep. At 8:45 AM, the BM found the SC unresponsive and with no pulse. He was very pale, yellowish and stiff. The BM called 911. EMS responded to the home, performed CPR on the SC and while transporting him to the hospital. When the SC arrived at the hospital, the medical staff continued CPR on the SC; however, he was unable to be revived. The ER Dr. pronounced the SC deceased at 9:20 AM.

The case documentation also revealed the SC had complications from his medical condition that required surgery after birth. The SC received care at the neo-natal intensive care unit for 9 days and was released to the parents. The parents completed all follow-up medical appointments for the SC and at every visit, the doctor told the parents the SC was healthy and fine. Between age 5 and 8 months, the SC suffered frequent discomfort due to his condition and was seen frequently at the ER; however, the ER staff would report no findings every time the SC was seen.

On 10/26/19, ACS received the report and initiated the CPS investigation. During the investigation, ACS obtained information from both hospital and LE staff which which did not indicate the SC's death was due to abuse or neglect. ACS obtained additional information from family members and neighbors. There were no reported concerns for the family.

On 12/16/19, ACS unsubstantiated the allegations of the report due to lack of credible evidence. The SC died of natural causes due to a medical condition from birth. There were no surviving children in the home.

At the time of the investigation closing, the parents refused ACS' offer of bereavement counseling services. They reported they did not need any assistance from ACS.

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

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' decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The pediatrician would have provided information about the overall medical care the SC received, the SC's care plans (if any), if the SC's death was expected due to his medical condition, and the parents' ability to adequately care for the SC.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/26/2019 **Time of Death:** 09:20 AM

Time of fatal incident, if different than time of death: 08:40 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 08:45 AM
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	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)

LDSS Response

On 10/26/19, ACS contacted the hospital staff who reported the SC was born with a medical condition and had had prior surgery as a result. Sometime in August 2019, the SC was treated at the ER and discharged to his parents. The staff did not report any concerns of neglect or maltreatment to the SC.

On 10/26/19 and 10/27/19, ACS made several unsuccessful attempts to contact the family; however, the family's neighbors reported the SC was well cared for by the parents.

On 10/27/19, the ME reported the SC's preliminary cause of death was Volvulus (An obstruction due to twisting or knotting of the gastrointestinal tract). The ME stated the SC's medical condition was due to a birth defect called malrotation which occurred during fetal development. The ME did not suspect any foul play regarding the SC's death.

On 10/28/19, the PGM's paramour confirmed that the SC was born with a medical condition and had been seen frequently at the ER due to his condition. Prior to his passing, the SC appeared to be developing appropriately. The paramour described the relationship between the parents and the SC as very loving. He denied the parents used drugs or alcohol. ACS did not observe any safety hazards in the home. There were no children in the home.

On 11/7/19, the BM declined to attend or participate in a family team meeting with ACS. ACS informed the BM that the family team meeting was to offer recommendations, resources and supports to the family. The BM asked ACS to send the information via email.

On 11/8/19, the family rejected ACS' offer of bereavement counseling services. The BM stated the family was able to look for services on their own and that they did not need any assistance from ACS. She agreed to a home visit by ACS.

On 11/12/19, ACS visited the family. They family reported the account of events prior to the SC's death, which was consistent with information that was already known. The parents wondered why the doctors kept telling them there was nothing wrong with their son at every medical visit and he eventually died from a medical cause.

On 11/21/19, the family complained that ACS was making them relive the circumstances that led to their son's death. They said they had provided ACS with all the information that was needed and wanted ACS to close their case. The BF stated the SC died due to a medical cause and said he would send ACS a copy of the SC's death certificate.

Later that same day, the BF informed ACS that the SC's death was not due to unsafe sleep. He stated the SC was put to sleep on his side in his crib and was found unresponsive on his side. The SC was placed to sleep with a pacifier, but the pacifier was not in the SC's mouth when he was found unresponsive. The SC was unobstructed by any person or object. The BF stated the SC's usual sleep place was the SC's crib. He denied the SC slept in the bed with him and the BM. He also denied the SC was exposed to secondhand smoke, as neither him nor the BM smoked.

Between 11/21/19 and 12/12/19, there was no new information regarding the SC's death.

On 12/16/19, ACS unsubstantiated the allegations of the report and closed the case with the closure reason: "Closed-Refused Services".

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

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

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053468 - Deceased Child, Male, 10 Mons	053470 - Father, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
053468 - Deceased Child, Male, 10 Mons	053469 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
053468 - Deceased Child, Male, 10 Mons	053470 - Father, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
053468 - Deceased Child, Male, 10 Mons	053469 - Mother, Female, 38 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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

The family did not have prior SCR history.

Known CPS History Outside of NYS

The family did not have any 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