NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-019 **Prepared by: New York City Regional Office**

Issue Date: 8/16/2016

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
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		

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 02/22/2016
Initial Date OCFS Notified: 02/23/2016

Presenting Information

At approximately 6:41 P.M. on 2/22/16, the police and EMS were called to the home due to an unresponsive seventeen-year-old child. The child was sick for ten days with a fever and headache yet the BM failed to seek medical care for him in a timely manner. It was not until the morning of 2/22/16 that the BM attempted to take the SC to the hospital but the SC refused. The SC did not have any preexisting medical conditions.

Executive Summary

According to ACS' investigation, the SC was sent home early on 2/12/16 from school due to a low grade fever. The BM gave the SC medication which reduced the fever but did not take him to see a Dr. On 2/13/16, the BM continued the medication regime along with fluids for the SC. Between 2/14/16 and 2/22/16, the SC's symptoms fluctuated and he was able to go to the movies with his family a week after his symptoms began. However, at approximately 6:00 P.M. on 2/22/16, the BM checked on the SC and found him unconscious and unresponsive in his bed. The BM called 911and attempted CPR on the SC as instructed over the phone by the 911 operator. The first responders arrived at the home moments later and found the SC unresponsive with a brownish discharge draining from his nose. The SC's body was already in rigor mortis. EMS pronounced the SC dead on the scene at 6:45 P.M. According to the ME, the SC's cause of death was complications of acute bacterial meningitis (Streptococcus Group C). The manner of death was natural.

There were no surviving siblings or minor children in the home. The SC's BF was incarcerated at the time of the fatality and was not involved with the family.

ACS initiated the investigation within the mandated time frame. The ECS' Specialist made contacts with the medical and police staff. The information obtained from both medical and police staff ruled out any criminality regarding the SC's death. In addition, the statements provided by the BM and the SC's adult siblings were consistent. ACS obtained additional information from the SC's school. The school did not report any concerns for the family.

On 6/16/16, ACS unsubstantiated the allegations of the report. ACS based its decision on the information obtained during the course of the investigation which revealed the SC died of natural causes. During the investigation, ACS offered the BM bereavement counselling services but she refused. ACS closed the case without services.

ACS exhibited good casework practice by contacting the New York City Department of Health (NYCDOH) regarding appropriate precautionary measures to be taken given that meningitis outbreak could occur in the SC's school or community. The NYCDOH was not concerned that it was a communicable disease.

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 was commensurate with the case circumstance.

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 offered the BM bereavement and supportive services but she refused.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Progress Notes
Summary:	Between 2/24/16 and 3/18/16, the Specialist did not document case related activities. The Specialist's last case note update was on 4/4/16.
Legal Reference:	18 NYCRR 428.5
Action:	The Administration for Children's Services (ACS) must submit a corrective action 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 attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/22/2016 **Time of Death:** 06:45 PM

County where fatality incident occurred: BRONX

Was 911 or local emergency number called? Yes

Time of Call: 06:40 PM
Did EMS to 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? No - Not needed given developmental age or circumstances

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	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	53 Year(s)

LDSS Response

On 2/23/16, the ACS Specialist initiated the investigation and contacted by phone the NYPD, EMS and the ME's office. The NYPD detective and the ME determined there was no criminality regarding the SC's death. The detective stated that no arrest had been made and EMS did not find anything suspicious in the immediate area of the SC's bed.

The Specialist then contacted the SC's school staff who reported that the SC had an individualized education program but no major behavioral issues. The school did not report any concerns for the SC or the BM.

On the same date, ACS contacted the New York City Department of Health (NYCDOH) regarding appropriate precautionary measures to be taken given that a meningitis outbreak could occur in the SC's school or a community. The assigned Dr. at NYCDOH was not concerned that it was a communicable disease.

On 2/24/16, the ME reported that the SC died from Meningitis. According to the ME, the SC had a form of bacterial meningitis which did not pose a public health issue. There was no protocol that the BM or family members needed to take and there was no medication required. Regarding the BM's failure to seek immediate medical attention for the SC, the ME stated the BM did what was appropriate given the type of meningitis the SC had. The BM could not have known the SC had meningitis. The ME further stated that the SC was current with all of the routine physicals and he had no medical issues.

Also on 2/24/16, the Specialist interviewed the family members. They did not provide any new information regarding the SC's death. The Specialist provided the family with the information regarding the symptoms of meningitis and advised them to follow up with their Dr. if there were any concerns regarding exposure. The Specialist offered the family

bereavement and supportive services but they refused.

On 4/4/16, the detective reported that the criminal investigation was closed because there was no criminality involved in the SC's death.

On 5/13/16, ACS obtained notification from the ME which indicated the SC's cause of death was complications of acute bacterial meningitis (Streptococcus, Group C). The manner of death was natural.

On 6/16/16, ACS unsubstantiated the allegations of the report and closed the case with no services needed.

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 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
025761 - Deceased Child, Male, 17 Yrs	025762 - Mother, Female, 53 Year(s)	DOA / Fatality	Unsubstantiated
025761 - Deceased Child, Male, 17 Yrs	025762 - Mother, Female, 53 Year(s)	Lack of Medical Care	Unsubstantiated
025761 - Deceased Child, Male, 17 Yrs	025762 - Mother, Female, 53 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:
There was a notable gap in the investigation progress notes between 2/24/16 and 3/18/16.

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: There is no documentation ACS offered financial assistance for the funeral of the SC.							

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 surviving minor siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS offered the BM and the SC's adult sibling bereavement and supportive services but they adamantly refused. Consequently, ACS closed the case with no services needed.

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? Yes

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history within three years prior to the fatality.

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

The family did not have any prior CPS history.

Known CPS History Outside of NYS

The family did not have any known CPS History outside of NYS.

Services Open at the Time of the Fatality

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.

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