NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-048 **Prepared by: New York City Regional Office**

Issue Date: 12/16/2015

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	MN-Medical Neglect	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: 2 year(s)
Jurisdiction: Richmond
Gender: Female
Date of Death: 06/15/2015
Initial Date OCFS Notified: 06/15/2015

Presenting Information

The SCR report alleged that on 6/15/15, at 9:05 A.M. the mother called for EMS after the SC fell from a changing table. EMS responded and transported the SC to the Staten Island University Hospital. However, the SC died of unspecified injuries. The report alleged that the mother's explanation was not consistent with the resulting death of the SC.

Executive Summary

The SC was two years old at the time of her death. The autopsy report listed the cause of death as undetermined and the manner of death as natural.

The family had no history with the SCR or ACS.

On 6/15/15, the SCR registered a report for allegations of DOA/Fatality and Inadequate Guardianship of the SC by the mother. At the time of the incident, the mother was alone with the SC as the father was at work and the two siblings were in school. EMS responded to the 911 call and transported the SC to the Staten Island University Hospital where they arrived at 9:18 A.M. Efforts to resuscitate the SC failed and she was pronounced dead at 9:48 A.M. The medical staff noted that the mother's explanation of the SC falling from the changing table could not have caused the SC's death. However, there were no concerns of foul play by the mother, as the SC had no evidence of abuse or maltreatment.

The NYPD ruled the death as an accident. However, an autopsy was completed and the cause of death was undetermined. ACS discussed the cause of death with the ME and ascertained that there was neither bacterial nor viral infection nor any anatomical abnormality noted at autopsy. In addition, the SC had no pre-existing medical condition, no internal or external trauma following the short fall (3-4ft) from the changing table to the carpeted floor, and no natural diseases or contributing toxicology were identified. The ME noted in the final diagnoses that the SC's death was sudden and of an unknown etiology. The manner of death was listed as natural.

ACS assessed the siblings were well cared for and they were deemed safe in the care of the parents. ACS also maintained the required biweekly contacts with the family. The home environment was always appropriate with no safety hazards present.

On 9/17/15, ACS unsubstantiated the allegations of the report citing the results of the autopsy report, which ruled the manner of death as natural. ACS also cited their extensive collateral contacts, which included family members, school staff, LE and pediatrician and none noted any concerns about the mother's ability to care for the SC or the siblings.

The report was unfounded and closed as the Risk Assessment and Risk Assessment Profile did not indicate the need for services.

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

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	Although there were no safety factors that presented an immediate or impending danger to the child(ren), the caseworker recorded safety decision #2. The case documentation did not support this decision.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan 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: 06/15/2015 **Time of Death:** 09:48 AM

County where fatality incident occurred: RICHMOND
Was 911 or local emergency number called? Yes
Time of Call: 09:05 AM
Did EMS to respond to the scene? Yes
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: Child was standing on a changing table

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:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☒ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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	Female	2 Year(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)

LDSS Response

Following the receipt of the SCR report, ACS conducted a comprehensive investigation which included contact with the NYPD, medical staff, the ME, and family members.

ACS learned the SC resided with her parents and two siblings in a three-bedroom apartment. The SC had her own room

and the siblings shared a room. There were provisions for all the children; the home was "immaculate" and there were no safety hazards present. The siblings were seen and deemed safe in the care of the parents.

On 6/15/15, the parents and the SC were up around 6:30 A.M., the SC and the BF watched cartoons while the BM made breakfast and prepared the siblings for school. The BF left for work at 7:20 A.M. The parents stated that the day began as usual with the exception that the MGPs drove the siblings to school as opposed to the BM.

The SC liked eating finger foods in the mornings and was fed cheerios, banana, and pretzels. At 8:55 A.M., the BM went to change the SC's diaper. The BM laid the SC on the changing table and the SC began moving around. The BM was standing by the table diagonally. The SC fell from the table and onto the floor, landing on her face. The changing table was approximately 3.5 feet from the ground. The room had wall-to-wall carpet with an area rug located about one foot away from the changing table. The carpet and the area rug were both flat. The BM said she never left the SC unattended.

The BM said the SC began to cry and she picked the SC up and tried to soothe her. The BM, while holding the child, walked to the living room to put on cartoons and bring the SC over to her toys as a distraction. However, the BM took about four steps out of the room before the SC "moaned" and tilted her head back. The BM stated that she immediately knew that something was wrong and dialed 911. As she was dialing 911, she also yelled out to the MGGF who lived on the ground floor of the home. The MGGF ran up the stairs and took the SC out of the BM's arms. He laid the SC on the floor in the living room and administered CPR. The BM estimated that she called 911 at about 9:00 A.M. and EMS arrived one or two minutes later.

After calling 911, the BM called the MGPs who resided three blocks away. EMS transported the SC in an ambulance, the mother and the MGM in a separate ambulance and the MGF followed in his car. The BM was unable to reach the BF on his cell phone, so she left a message for him to meet her at the hospital. The BF said that once he arrived at the ER, the BM explained that the SC fell off the changing table.

The medical staff noted that the mother's explanation of the SC falling from the changing table could not have caused the SC's death. However, neither the NYPD nor the medical staff had concerns of foul play by the BM, as the SC had no evidence of abuse or maltreatment.

ACS interviewed family members, school officials and the children's pediatrician and none had any concerns about the parents' ability to care for the children. ACS maintained a good relationship with the family and was allowed to make the required bi-weekly home visits to the case address. There were no concerns noted during these visits.

On 9/17/15, ACS unsubstantiated the allegations of the report citing the results of the autopsy report, which ruled the manner of death as natural. ACS also cited their extensive collateral contacts, which included family members, school staff and pediatrician as none noted concerns about the mother's ability to care for the SC or the siblings.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Undetermined if injury or 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 investigations.

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
017901 - Deceased Child, Female, 2 Yrs	017902 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
017901 - Deceased Child, Female, 2 Yrs	017902 - Mother, Female, 30 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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?	☐	☐	☒	☐

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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household	☐	☒	☐	☐

removed as a result of this fatality report/investigation?				

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:
The family declined services offered by ACS; however, the found services on their own.

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:
No immediate services were needed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
No immediate services were 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?	No

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 had no CPS history.

Known CPS History Outside of NYS

The family had no CPS history outside 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