NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-14-088 **Prepared by: New York City Regional Office**

Issue Date: 2/5/2015

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 OC = Other Child MGM/PGM = Maternal/parental Grandmother	SM = Subject Mother BF = Biological Father FM = Foster Mother MGF/PGF = Maternal/parental Grandfather	SC = Subject Child SF = Surviving Father FF = Foster father DCP = Day Care Provider
Contacts LE = Law Enforcement EMS = Emergency Medical Services DC = Day Care	CW = Caseworker Dr = Doctor CPR = Cardiopulmonary Resuscitation	CP = CasePlanner ME = Medical Examier FD = Fire Department
Allegations L/B/W = Lacerations/Bruises /Welts B/S = Burns / Scalding PD/AM = Parent's Drug Alcohol Misuse M/FTTH= Malnutrition/Failure--to-Thrive LS = Lack of Supervision OTH/COI = Other	FX = Fractures S/D/S = Swelling/Dislocation /Sprains CD/A = Child's Drug/Alcohol Use P/Nx = Poisoning/ Noxious Substance IF/C/S = Inadequate Food/Clothing /Shelter Ab = Abandonment	II = Internal Injuries C/T/S = Choking/Twisting /Shaking MN = Medical Neglect XCP = Excessive Corporal Punishment IG = Inadequate Guardianship SO = Sex Offender
Miscellaneous LDSS = Local Department of Social Service	IND = Indicated ACS = Administration for Children's Services	UNF = Unfounded NYPD = New York City Police Department

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 08/07/2014
Initial Date OCFS Notified: 08/15/2014

Presenting Information

On 7/30/14 at 9:00 AM, the father placed the infant on the adult bed surrounded with pillows while the infant slept. At 9:15 AM, the father checked the infant and she was still sleeping. At 10:00 AM, the father found the infant wedged between the wall and mattress with blood on the sheet. The infant was not breathing; she was revived, but suffered significant brain injury. On 8/7/14, the infant passed away from cardiac arrest as a result of suffocation.

Executive Summary

The six-month-old infant died in Queens County on 8/7/15. According to an ACS Investigation Progress Note dated 1/16/15, the ME provided preliminary findings which showed the infant's death was ruled as accidental. Also, the infant's injury was consistent with the parents' explanation that the infant was wedged between the mattress and the wall. The autopsy report was pending further review. As of 2/4/15, the OCFS has not yet received the autopsy report.

The 8/15/14 SCR report included the allegations of DOA/Fatality, IG and LS of the infant by the father.

The assigned ACS staff interviewed the parents, household members, medical staff, NYPD and other collaterals. Also, ACS conducted adequate visits to the case address and assessed the safety of the surviving sibling and the other child who resided in the home. The family's needs were identified during a Child Safety Conference and appropriate referrals for services were made. ACS involved the family with the development of the service plan and the family complied with the service plan requirements.

On 1/17/15, ACS substantiated the allegations of DOA/Fatality, IG and LS of the infant by the father on the basis that the infant had a bassinet or pack n' play to utilize; however, the father placed the infant surrounded by pillows in the bed and left the infant unsupervised. The father exercised poor judgment when he chose not to utilize the appropriate sleeping arrangements for the infant. The infant was found wedged between the mattress and wall, she suffered cardiac arrest due to lack of oxygen to the brain, on 8/4/14 she was declared brain dead and she passed away on 8/7/14.

ACS added to the report and substantiated the allegations of DOA/Fatality, IG and LS of the infant by the mother. The mother observed the infant surrounded by pillows in the bed; however, the mother did not move the infant into the bassinet or pack n' play. The infant was found by the mother wedged between the mattress and the wall. The parents were engaged in unsafe sleeping practices. The physician who treated the infant, following the 7/30/14 incident, stated the infant's death was due to lack of oxygen to the brain.

ACS appropriately investigated the allegations and found credible evidence to indicate the report.

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?** No
  - **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

Was the decision to close the case appropriate? N/A

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:
According to the ACS case record on 8/22/14, the case was opened for preventive services.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Child Fatality Report was approved on 8/15/14, however, this report did not include the required details about the case circumstances.
Legal Reference:	CPS Program Manual, VIII, B.1, page 2
Action:	ACS must meet with staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/07/2014 **Time of Death:** 05:50 PM

Date of fatal incident, if different than date of death: 07/30/2014
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Unknown if they were impaired.

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	Aunt/Uncle	No Role	Female	41 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	76 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	72 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Other Child	No Role	Male	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

This report involves the death of a six-month-old infant on 8/7/15 in Queens County. As of 2/3/15, NYCRO has not yet received the ME's report.

On 8/15/14, the SCR registered a report which included the allegations of DOA/Fatality, IG and LS of the infant by the father.

The ACS staff interviewed the parents, family members, medical staff, assigned NYPD detective and relevant collaterals. The parents' account of events remained consistent. According to the ACS case record, the assigned detective stated the parents provided similar accounts of the incident. There was no criminality noted. The medical staff diagnosed the infant

with cardiac arrest related to accidental suffocation. There was no internal trauma or bruises found on the infant's body. The infant's physician said the parents were compliant with medical appointments. On 5/28/14, the infant last received well-child evaluation. The physician noted the infant was able to move on her side from belly to back. The safe sleep practices were discussed with the mother. There were no concerns noted.

On 8/21/14, a Child Safety Conference was held and ACS offered the family Purchased Preventive Services. The service plan included bereavement and mental health counseling, drug treatment for the father and monitoring of therapeutic services for the surviving sibling. The Family Services Stage was opened and the family received preventive services. The parents complied with the service plan. Also, the parents tested negative for drugs. ACS reviewed the sibling's school records, interviewed school officials and found there was no concern regarding the sibling's educational needs.

On 1/16/15, the ME informed ACS staff that pending further investigation, the injury was consistent with the parents' explanation. The preliminary cause of death would be listed as accidental, but the parents needed to be re-interviewed regarding the infant's positioning before the decision was determined.

On 1/17/15, ACS substantiated the allegations of IG and LS of the infant by the father on the basis that although the infant had appropriate sleeping arrangements, the father left the infant unsupervised on the bed surrounded by pillows. ACS added and substantiated the allegations of DOA/Fatality, IG and LS of the infant by the mother. ACS noted the mother observed the infant on the bed unsupervised prior to finding her wedged between the mattress and wall; she failed to put her in the bassinet. The infant suffered cardiac arrest due to lack of oxygen to the brain and was declared brain dead on 8/4/14; her heart function seized on 8/7/14. The physician stated the infant's death was due to a lack of oxygen to the brain.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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: The fatality was not reviewed by an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
Deceased Child Female 6 Month(s)	Father Male 39 Year(s)	Lack of Supervision	Substantiated
Deceased Child Female 6 Month(s)	Father Male 39 Year(s)	DOA / Fatality	Unsubstantiated
Deceased Child Female 6 Month(s)	Father Male 39 Year(s)	Inadequate Guardianship	Substantiated
Deceased Child Female 6 Month(s)	Mother Female 39 Year(s)	DOA / Fatality	Unsubstantiated

Deceased Child Female 6 Month(s)	Mother Female 39 Year(s)	Inadequate Guardianship	Substantiated
Deceased Child Female 6 Month(s)	Mother Female 39 Year(s)	Lack of Supervision	Substantiated

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?	☒	☐	☐	☐
The SCR Report source contacted?	☒	☐	☐	☐
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 instigation?	☐	☒	☐	☐
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 father was referred to services. However, the ACS case record did not include adequate details regarding this referral.

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? Yes
Explain:
The service plan included monitoring of therapeutic services for the surviving sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The father was referred to an outreach drug program to address his marijuana usage. The family received a referral for bereavement counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/30/2014	831-Deceased Child,Female, 6 Months	701-Mother,Female, 39 Years	Inadequate Guardianship	Indicated	Yes
	831-Deceased Child,Female, 6 Months	701-Mother,Female, 39 Years	Internal Injuries	Indicated	
	831-Deceased Child,Female, 6 Months	702-Father,Male, 39 Years	Inadequate Guardianship	Indicated	
	831-Deceased Child,Female, 6 Months	702-Father,Male, 39 Years	Internal Injuries	Indicated	

Report Summary:
On 7/30/14, the father went to sleep alongside the five-month-old infant in the bed. At approximately 9:00 A.M., the father woke and the infant remained asleep in the bed. The father surrounded the infant with pillows and then left the room. Approximately 15 minutes later, the father checked the infant and found the infant was in the same position and remained asleep. At approximately 10:00 A.M., the mother found the infant wedged between the mattress and wall, the infant was not breathing, there was blood coming from her nose and she went into cardiac arrest. The mother contacted 911 and EMS responded. The infant was revived at the hospital, but suffered significant brain injury.

Determination: Indicated | **Date of Determination:** 09/26/2014

Basis for Determination:
ACS substantiated the allegation of II and IG of the infant by the parents on the basis that the father exercised poor judgment when he placed the infant on the bed surrounded by pillows and leaving the infant unsupervised. Despite the mother's observations of the infant's improper sleeping arrangements, she did not remove the infant from the bed to place the infant in the bassinet or pack n' play, which was available for the infant. The parents engaged in unsafe sleeping practices. The infant was found wedged between the mattress and wall: she suffered cardiac arrest due to lack of oxygen to the brain. On 8/4/14, she was declared brain dead and on 8/7/14, she passed away.

OCFS Review Results:
The ACS investigation was incomplete as the case record did not include adequate information to support the determination. The ACS Investigation Progress Notes stated the family practiced safe sleep and this was an isolated incident.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
In the safety assessment dated 8/6/14, ACS did not identify the safety factor that actually placed the child in immediate or impending danger of serious harm.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
ACS must meet with staff involved in this investigation and inform NYCRO of the date of the meeting, who attended and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issue.

Issue:
Appropriateness of allegation determination

Summary:
In the CPS Investigation Summary ACS substantiated for internal injuries of the baby. In the course of the investigation medical staff and the Medical Examiner reported there were no internal injuries or bruises / marks on the baby's body.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
ACS must meet with staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issue.

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

The family did not have CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no 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 legal activity as a result of 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