NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-16-002 **Prepared by: Spring Valley Regional Office**

Issue Date: 5/4/2016

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: 3 year(s)
Jurisdiction: Nassau
Gender: Female
Date of Death: 11/22/2014
Initial Date OCFS Notified: 01/16/2016

Presenting Information

On 01/16/2016, a report was called in to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) that stated, fifteen months prior, the subject child was under the care and supervision of her mother. The mother left the subject child in her bedroom alone and unsupervised for an unknown amount of time. When the mother checked on the subject child, she observed a plastic bag over her and she was unresponsive. Emergency services was called and police and EMS responded. The subject child was pronounced dead on arrival at the hospital. On 1/16/2016, the mother gave birth to a baby boy, and the father of the baby boy disclosed the information pertaining to the subject child. The father reported that according to the police, the death was accidental. There was police involvement but no CPS involvement.

Executive Summary

On 1/16/2016, a case was called in to the SCR alleging DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the mother on behalf of the subject child, who died on 11/22/2014. During the course of the investigation, it was learned that the mother, the half-sibling's father and the three-year-old female subject child were packing their belongings to move into a new residence. The subject child was alone in her bedroom watching television for approximately 5-10 minutes while the mother spoke with the half-sibling's father. The mother had gone into the bedroom to check on the subject child and found her on the floor of the room, unresponsive. The surviving half-sibling's father was exiting the home at the time, and explained that he heard the mother "wail," as he was leaving. When he ran into the subject child's bedroom, he observed the subject child had a plastic bag on her head, and she was unresponsive on the floor. The mother began CPR on the subject child. At approximately 10:35 AM, the half-sibling's father called 911 before taking over resuscitative efforts on the subject child. The subject child was transported to the hospital by EMS where he was pronounced dead at 11:19 AM from cardiopulmonary arrest. The police investigation determined the subject child's death to have been a tragic accident and no arrests were made. There was no CPS involvement at the time of, or as a result of this fatality. Medical records indicated that the subject child was seen regularly by the pediatrician and no concerns were noted. The subject child's biological father was present at her funeral, however was not involved in the life of the subject child.

On 1/16/2016, the mother gave birth to the male half-sibling. Home visits to assess the safety and well-being of the half-sibling were made and contact was maintained throughout the course of the investigation. Appropriate provisions for the half-sibling were observed and no concerns were noted in the home. The half-sibling was also regularly seen by a pediatrician and no concerns were noted regarding his care.

The Nassau County Medical Examiner's office conducted an autopsy on the subject child on 11/23/2014. The autopsy revealed the cause of death to have been "Asphyxia due to placement of plastic bag over head," and the manner of death was listed as "Accident." Local law enforcement officials investigated the death of the subject child, and did not file an SCR report at the time of the death or pursue any criminal charges. There was no pattern noted of the mother leaving the subject child alone or unattended, and this appeared to have been a tragic accident. The pediatrician noted no concerns of abuse and/or neglect.

The CPS investigation was closed on 03/14/2016. The allegations on the report were determined to have been un-substantiated regarding the mother, on behalf of the subject child for Inadequate Guardianship, Lack of Supervision and DOA/Fatality. Services were offered to the family, however declined. The family was not interested in receiving bereavement counseling services as they had already grieved the loss of the subject child and did not want to relive the trauma.

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:
The decision to unfound the allegations and close the case was appropriate.

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 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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/22/2014 **Time of Death:** 11:19 AM

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: 10:35 AM
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? Yes
How long before incident was the child last seen by caretaker? 10 Minutes
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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	28 Year(s)

LDSS Response

Nassau County Department of Social Services, (NCDSS), conducted an investigation into the allegations listed on the report. NCDSS did make many appropriate collateral contacts including the Medical Examiner, local law enforcement officials, hospital staff, and community resources. All subjects and other persons named on the report were interviewed and observed, and the allegations were discussed. Appropriate service referrals were offered to the family.

There were no surviving siblings at the time of the fatality. On 1/16/2016, the male, half-sibling was born. His safety was assessed and contact with him was maintained throughout the investigation. NCDSS completed all safety assessments. All assessments were timely, and appropriate. The case notes were well documented, detailed and all were contemporaneous. As per the Medical Examiner's office, an autopsy was completed on the subject child on 11/23/2014. The final autopsy report listed the cause of death as "Asphyxia due to placement of plastic bag over head," and the manner of death was listed as accidental. There was police involvement and local law enforcement officials explained this incident to have been

a tragic accident. No criminal charges were filed. There was no CPS involvement at the time of or as a result of this fatality.
There was documentation of supervisory conferences noted in which the circumstances of the case were discussed and directives were provided.

The investigation was closed on 03/14/2016 and the allegations on the report were determined to have been un-substantiated regarding the mother, on behalf of the subject child for Inadequate Guardianship, Lack of Supervision and DOA/Fatality. The subject child's death was determined to have been accidental.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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: This fatality occurred on 11/22/2014. There was police involvement, however there was no CPS involvement at the time of the fatality. NCDSS made numerous collateral contacts with local law enforcement officials regarding their investigation, however this fatality investigation was not conducted by an MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This case was discussed at the Child Fatality Review Team meeting held on 3/15/2016.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
026481 - Deceased Child, Female, 3 Yrs	026482 - Mother, Female, 33 Year(s)	Lack of Supervision	Unsubstantiated
026481 - Deceased Child, Female, 3 Yrs	026482 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
026481 - Deceased Child, Female, 3 Yrs	026482 - Mother, Female, 33 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

Additional information:

Emergency room personnel was not contacted as the fatality occurred on 11/22/2014. Sufficient information was gathered from local law enforcement officials in lieu of this contact being made.

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 or 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?	☐	☒	☐	☐
Explain as necessary: There was no removal of the surviving half-sibling required.				

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:
Bereavement counseling services were offered to the family; however the family declined.

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:
Services were offered to the family, however refused.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered to the family, however refused.

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? N/A
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

There is no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

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