# NYS Office of Children and Family Services - Child Fatality Report

**Report Identification Number: NY-14-111** **Prepared by: New York City Regional Office**

**Issue Date: 4/10/2015**

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-plumonary 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 Suprevision |
| 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 month(s)
**Jurisdiction:** Kings
**Gender:** Male
**Date of Death:** 10/17/2014
**Initial Date OCFS Notified:** 10/19/2014

## Presenting Information

The twins were born prematurely at 32 weeks gestation. The twins had medical complications due to preexisting medical conditions and from birth, they remained in the Neonatal Intensive Care Unit until one (surviving sibling) was discharged on 9/12/14 and the other (now deceased child) was discharged on 10/13/14. On 10/17/14, the nanny was in the home with the twins. At around 8:30 PM, the nanny fed, then lay the infant face up in his bassinet. Later, the infant was found unresponsive. The nanny contacted 911 and started CPR. The infant was in cardiac arrest and transported to Woodhull Hospital by ambulance. The infant was pronounced dead at 10:37 PM on 10/17/14. During an examination, it was discovered the infant had a subdural hemorrhage on his brain. A subdural hemorrhage is not typical for a child who was born premature with preexisting breathing issues, making the injury and death suspicious. The role of the surviving twin was unknown.

## Executive Summary

This two-month-old male twin infant died on 10/17/14. As of 4/10/15, NYCRO has not yet received the ME's report.

The 10/19/14 SCR report included the allegations of DOA/Fatality and IG of the infant by the parents and two nannies.

During the investigation, ACS staff interviewed the family members, nannies, NYPD, physicians, ME and other collaterals. ACS' investigation revealed the twins were born prematurely at 32 weeks gestation and remained hospitalized until 9/12/14 when the sibling was discharged and 10/13/14 when the now deceased infant was discharged. On 10/17/14, at approximately 7:00 PM, the parents left the twins in the care of the nanny 1. At about 8:00 PM, nanny 1 last fed the infant and at 8:45 PM, she placed him in his bassinet to sleep. At about 9:15 PM, she observed he was not breathing, he had reddish fluid in his nose and his skin was a blue color. She contacted 911 and followed the CPR instructions until EMS responded.

EMS transported the infant to the Woodhull Hospital where he was pronounced dead. The attending physician observed the infant was pale with red areas on the skin. The infant did not have marks or bruises and there was no observable sign of abuse/maltreatment. The NYPD investigation showed the home was clean with no hazardous conditions.

On 10/17/14, the nanny contacted the parents and informed them of the incident. The parents returned home, left the sibling in the care of nanny 1 and went to the hospital where they learned of the infant's death. ACS verified on 10/18/14, the sibling received medical examination at Bellevue Hospital. The examination revealed the sibling was healthy. The Specialist interviewed the primary physician who did not have concerns about the care the twins received.

The preliminary autopsy results revealed the infant had a minor subdural hemorrhage on the brain and three rib fractures. The ME said the bleeding between the brain and vessels that supply blood to the brain was possibly an injury caused by another person and the bleeding and rib fractures were recent. The infant had no known blood disorder or evidence of aneurism.

On 3/2/15, the Specialist last observed the mother and sibling in the home; the sibling was fine. The family continued to receive ACS Court Ordered Supervision. In March 2015, the ME said the autopsy was pending results of additional tests.

As of 4/10/15, the investigation which began on 10/19/14 has not yet been completed.

## 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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

**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:**
On 10/23/14, ACS opened the Family Services Stage to provide the family with preventive services. The service plan included case management, Early Intervention and casework counseling. The family refused the offer for Purchased Preventive Services. However, the case remained open for Court Ordered Supervision.

### Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Timely/Adequate 24 Hour Assessment |
| **Summary:** | On 10/24/14, ACS completed the 24-hour child fatality safety assessment for the 10/19/14 report. |
| **Legal Reference:** | SSL 424(6);18 NYCRR 432.2(b)(3)(i) |
| **Action:** | ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations 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:** 10/17/2014 **Time of Death:** 10:37 PM

**Time of fatal incident, if different than time of death:** Unknown

**County where fatality incident occurred:** KINGS
**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?** No
**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 | Male | 2 Month(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 44 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 44 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 2 Month(s) |
| Other Household 1 | Other | Alleged Perpetrator | Female | 53 Year(s) |
| Other Household 1 | Other | Alleged Perpetrator | Female | 29 Year(s) |

### LDSS Response

The nanny 1 said at about 5:30 PM, when she arrived in the home she observed the mother feeding the infant. The mother

said the infant appeared congested and there was mucus coming out of his nose. The nanny 1 used a bulb aspirator and suctioned mucus from the infant's nose. At about 8:00 PM, she last fed and burped the infant and at 8:45 PM, she placed the twins in their respective bassinet to sleep. She checked the infant at approximately 10-minute intervals until approximately 9:30 PM when she observed he was not breathing and there was reddish mucus in the nose area. She performed CPR until EMS responded to the home. The nannies said they placed the twins on their backs to sleep but the mother wanted the twins placed on their stomachs with the neck tilted to the right side to sleep. ACS found, on 10/17/14, NYPD responders observed there was a blanket rolled around the bassinet as a makeshift bumper. The infant was reportedly placed in the bassinet with his head tilted to the side closer to the makeshift bumper to sleep. However, ACS' case record did not reflect this issue was addressed with the parents.

ACS obtained the preliminary autopsy findings which showed the infant had bleeding between the brain and vessels that supply blood to the brain, possibly an injury caused by another person. Also, the infant had bleeding around the rib fractures indicating the fractures were recent. The toxicology report was negative but the autopsy was pending additional tests.

The primary physician said on 10/16/14, the infant received well-child examination. The infant did not have observable marks or bruises, his lungs were clear and his breathing was fine. On 9/26/14, the surviving sibling received examination for illness and this physician advised the parents to use nasal saline drops and the bulb aspirator. A nanny accompanied the mother at each visit and the nanny appeared very knowledgeable about child care. This physician said a subdural hemorrhage may be the result of birth trauma as dropping or bumping an infant's head would have likely also resulted in external bruising, swelling or other external signs of injury. The physician added that tests completed on healthy infants may reveal some blood in the brain. Also, on 10/21/14, ACS obtained a child advocacy center review in which a physician advised the agency that the infant's rib fractures and subdural hemorrhage were moderately suspicious. In addition, ACS obtained a medical consultation which resulted in a recommendation to obtain the autopsy report.

The Specialist maintained adequate contact with the family and observed the sibling was fine. The family no longer uses nanny service.

As of 4/10/15, ACS has not yet completed the investigation of the 10/19/14 report.

## 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 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 this local district.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 014742 - Deceased Child, Male, 2 Mons | 014746 - Other - Nanny, Female, 53 Year(s) | Inadequate Guardianship | Pending |
| 014742 - Deceased Child, Male, 2 Mons | 014746 - Other - Nanny, Female, 53 Year(s) | DOA / Fatality | Pending |
| 014742 - Deceased Child, Male, 2 Mons | 014747 - Other - Nanny, Female, 29 Year(s) | DOA / Fatality | Pending |
| 014742 - Deceased Child, Male, 2 Mons | 014747 - Other - Nanny, Female, 29 Year(s) | Inadequate Guardianship | Pending |
| 014742 - Deceased Child, Male, 2 Mons | 014743 - Mother, Female, 44 Year(s) | DOA / Fatality | Pending |
| 014742 - Deceased Child, Male, 2 Mons | 014743 - Mother, Female, 44 Year(s) | Inadequate Guardianship | Pending |
| 014742 - Deceased Child, Male, 2 Mons | 014744 - Father, Male, 44 Year(s) | DOA / Fatality | Pending |
| 014742 - Deceased Child, Male, 2 Mons | 014744 - Father, Male, 44 Year(s) | Inadequate Guardianship | Pending |

**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:**

The Specialist attempted to contact EMS to obtain information about the time of the 911 call, observation of home

conditions and other pertinent details. According to the ACS case record, the attempt was unsuccessful: the EMS staff did not respond.

**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:<br>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?**

☒Family Court ☐Criminal Court ☐Order of Protection

| **Family Court Petition Type:** FCA Article 10 - CPS | | |
|---|---|---|
| **Date Filed:** | **Fact Finding Description:** | **Disposition Description:** |
| 10/24/2014 | There was not a fact finding | There was not a disposition |
| **Respondent:** | 014743 Mother Female 44 Year(s) | |
| **Comments:** | On 10/22/14, ACS filed an Article Ten Neglect petition in Kings County Family Court on behalf of the surviving sibling, naming the parents as the respondents. The Court issued a short order granting the parents supervised visits by the family friend resource or any other ACS approved resource. During the 10/24/14 hearing, the surviving sibling was released to the maternal grandparents at the parents' home, with ACS supervision. As a result of the Family Court decision, the maternal grandparents temporarily resided in the parents' home. Subsequently, the maternal grandparents returned to their home which is located abroad. In November 2014, the Court found there was no imminent risk as various medical professionals found the infant's death may be due to many causes that were non-accidental. The Fact Finding which was scheduled for 2/23/15 was adjourned to 4/20/15. The Court Ordered Supervision remained until the next court date. | |

## 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:**
During the most recent Family Court hearing, the judge limited ACS' supervision to one time per month, announced home visit only, absent any new intervening information. The family refused the referral for Early Intervention services and Purchased Preventive Services.

**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 family received Court Ordered Services under ACS supervision.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
The family received Court Ordered Services under ACS supervision.

## 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

### 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 within three years prior to the fatality.

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

The family was not known to the SCR of ACS.

### Known CPS History Outside of NYS

There was no known 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