NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-15-037 **Prepared by: Spring Valley Regional Office**

Issue Date: 3/10/2016

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: 1 year(s)
Jurisdiction: Rockland
Gender: Female
Date of Death: 08/17/2015
Initial Date OCFS Notified: 08/17/2015

Presenting Information

On 8/17/2015, a case was called in to the New York Statewide Central Register of Child Abuse and Maltreatment with allegations of DOA/Fatality and Inadequate Guardianship against the mother and the father on behalf of the one-year-old female subject child. The report alleged the subject child had a fever that was treated with Motrin by the mother the night prior and was placed on her back in her crib. Seven hours after the mother last checked on the subject child, the subject child was found lying face down in her crib with a pacifier in her mouth, unresponsive and stiff. The subject child was not noted to have a history of medical concerns and was an otherwise healthy child.

A subsequent report was called in 1.5 hours later on the same day with the same allegations. This report added the subject child was vomiting the night prior. No additional details were included in the second report that were not listed on the first.

Executive Summary

Rockland County Department of Social Services, (RCDSS), conducted an investigation into the allegations listed on the report, and worked in conjunction with Local Law Enforcement Officials. RCDSS made many collateral contacts and obtained pertinent information to determine all of the allegations listed on the report. All subjects named on the report were interviewed, and the allegations were discussed in detail. Home visits were made and contact was maintained with the family.

The mother reported that on 8/16/2015, the subject child had a low-grade fever, and had vomited one time during the day. The mother administered Motrin to the subject child, which he spit out. The subject child was put to bed around 7:00 PM. At 11:00 PM, the mother checked on the subject child and everything seemed “normal.” Concerned that the subject child had not woken up during the night, the mother went to check on him early in the morning and found the subject child stiff, and face down with his pacifier in his mouth. A 911 call was received at 6:06 AM and Emergency Medical Services (EMS) responded to the case address. Cardiopulmonary Resuscitation (CPR) was administered however the subject child remained unresponsive. Efforts to intubate the subject child were unsuccessful as it appeared as though Rigor Mortis had begun to set in and the subject child’s teeth were clenched shut. The subject child was transported to the local hospital where resuscitation efforts continued. The time of death for the subject child was called at 7:01 AM. The parents were present at the bedside.

Only an external autopsy was completed due to the parent’s religious objections, and no evidence of physical trauma was observed. The subject child had no history of medical concerns. As per the Medical Examiner, an unexpected result for Oxycodone was received back from the toxicology lab in regard to the subject child. The Medical Examiner noted that there should be absolutely no amount of this drug in the subject child’s system, however could not verify that the Oxycodone was the cause of death. Without completion of an internal autopsy, the cause of the subject child’s death was ruled “Undetermined.” Both parents denied ever having taken Oxycodone, nor that there is any in the home. No causal connection could be established between the findings and any action of the parents. Local Law Enforcement Officials did not take any criminal action against the parents in regard to the incident.

All Safety Assessments as well as the Risk Assessment Profile (RAP) were appropriate, timely, and accurately reflected the known circumstances of the case. The case notes were well documented, detailed and contemporaneous.

On 10/13/2015, RCDSS made the determination to unsubstantiate the allegations of DOA/Fatality Inadequate Guardianship listed on the report against the mother and father on behalf of the subject child. The mother and father were cooperative with RCDSS and Local Law Enforcement Officials, and there was no evidence of Oxycodone being found in the home. RCDSS was unable to obtain any evidence to support that the subject child had ingested the Oxycodone while in the care of the mother and/or father. Local Law Enforcement's investigation also revealed no concerns. Although a toxicology screen revealed the presence of Oxycodone in the subject child's system, the Medical Examiner could not determine if the Oxycodone was the cause of the subject child's death without an internal autopsy. The family has extended and reliable resources within the community and were working with their religious leader for bereavement counseling at the time the investigation was closed. The family declined service referrals made by RCDSS.

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:
All assessments and the determination accurately reflected the known circumstances of the investigation.

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: 08/17/2015 **Time of Death:** 07:01 AM

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

County where fatality incident occurred: ROCKLAND
Was 911 or local emergency number called? Yes
Time of Call: 06:06 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
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? 7 Hours
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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)

LDSS Response

Rockland County Department of Social Services, (RCDSS), conducted an investigation into the allegations listed on the report, and worked in conjunction with Local Law Enforcement Officials. RCDSS made collateral contacts with the District Attorney's Office, first responders, family members, the Medical Examiner, medical professionals and community resources. All subjects named on the report were interviewed, and the allegations were discussed.

There were no surviving siblings or other minor children residing in the home at the time of the investigation. All Safety Assessments as well as the Risk Assessment Profile (RAP) were appropriate, timely, and accurately reflected the known

circumstances of the case. The case notes were well documented, detailed and contemporaneous. There were no court petitions filed and no criminal charges made.

There was documentation of supervisory conferences, and Multi-Disciplinary Team meetings noted. The investigation was closed on 10/13/2015, and the allegations on the report were determined to have been unsubstantiated against the mother and the father on behalf of the subject child. Bereavement service referrals were offered to the family however declined. The family was receiving services via their religious leader who specializes in helping family cope with tragic events. Due to religious beliefs the Medical Examiner completed a non-invasive exam of the subject child and listed the manner of death as "Undetermined."

Official Manner and Cause of Death

Official Manner: Undetermined
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)?Yes
Comments: This fatality investigation was conducted by an MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Rockland County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
020301 - Deceased Child, Female, 1 Yrs	020303 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated
020301 - Deceased Child, Female, 1 Yrs	020303 - Father, Male, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
020301 - Deceased Child, Female, 1 Yrs	020302 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
020301 - Deceased Child, Female, 1 Yrs	020302 - Mother, Female, 28 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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
All appropriate collateral contacts were made and pertinent information was obtained.

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:
Bereavement services were offered to the family, however declined. The family was receiving services via their religious leader who specializes in helping families cope with tragic events.

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 siblings or other children residing in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
Services were offered to the family, however declined as a result of the family already being engaged in services via community resources.

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? 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

There is no known history on file for the family.

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