NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-052 **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 **Jurisdiction:** Queens **Date of Death:** 07/01/2015
Age: 2 year(s) **Gender:** Female **Initial Date OCFS Notified:** 07/01/2015

Presenting Information

The 7/1/15 SCR report alleged the parents failed to properly secure a clothes dresser in their home. On 6/30/15, the mother was not adequately supervising the two-year-old child. The child was opening and closing the dresser drawers. As a result the dresser fell on top of the child causing head trauma, which resulted in her death on 7/1/15.

Executive Summary

The two-year-old female child died on 7/1/15. According to the ACS case record, the ME stated the cause of death was blunt impact to the head and the manner of death was an accident; however, as of 12/16/15, NYCRO has not yet received the final autopsy report to confirm the information.

The allegations of the 7/1/15 report were DOA/Fatality and IG of the two-year-old child by the parents and LS of the child by the mother.

ACS initiated the investigation within 24 hours of receipt of the 7/1/15 SCR report. ACS' investigation revealed that prior to the fatality the mother had sustained an injury which impaired her mobility. Due to the mother's injury, the MGF assisted with caring for the child in the home. On 6/30/15, at an undetermined time, the MGF took the child to the park. Upon their return from the park, the mother played with the child in the living room and then the child went to her bedroom. The mother remained on the sofa in the living room where she was able to observe the child's activities. The mother observed the child open the bottom drawer to the dresser and she assumed that the child was retrieving a blanket to play. The mother observed the child open the second drawer (second bottom up) and saw her lift her leg as if to climb on the dresser drawer. The mother called out to the child to prevent the child from climbing on the dresser. The child looked at the mother and smiled, and at that moment the mother observed the dresser falling forward on the child.The ACS case record did not include the approximate time the mother observed the dresser fall on the child's body.

The MGF was in the kitchen and the mother called out for his assistance. The MGF responded and went to the child's room where he observed the dresser had fallen on the child. He lifted the dresser off the child and saw that the child was unconscious. He said the child had never attempted to climb on the dresser before. The mother contacted 911 for assistance and she initiated CPR on the child. The mother observed the child's lips turned blue. EMS responded to the home and transported the child to the hospital. ACS did not interview EMS to obtain information about observations of child, the family members and the home environment. The hospital medical staff attempted to resuscitate the child; however, the attempts were unsuccessful as the child remained unresponsive. ACS did not obtain information from the attending physician who examined the child upon arrival in the hospital.

The findings showed prior to 7/1/15, neither the mother nor MGF had observed the child attempt to climb the dresser. ACS' staff observed the dresser in the child's room. The ACS staff described the dresser as light brown, measuring about five feet tall and including five drawers. There were clothing items in the drawers and on the top of the dresser. The dresser was heavy with "four round legs on each corner." ACS established that at time of the incident involving the child's death, the father was not in the home. The Specialist offered the family bereavement services and burial

assistance but the services were declined.

On 8/4/15, ACS unsubstantiated the allegations of DOA/Fatality, IG and LS of the child on the basis that the ME listed the cause of death as blunt impact to the head and the manner of death was an accident. ACS noted there was no credible evidence to suggest the parents failed to provide adequate guardianship to the child. The father was at work at the time of the incident. There was no credible evidence found that suggested the mother failed to provide adequate supervision. The mother was unable to stop the dresser from falling on top of the child due to her limited mobility which impeded her from moving appropriately.

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:
NA

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:
There are no surviving siblings.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Documentation did not reflect that first responders such as EMS or the emergency room Dr. were interviewed regarding the incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
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: 07/01/2015 **Time of Death:** 03:06 AM

Date of fatal incident, if different than date of death: 06/30/2015
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 1
At time of incident supervisor was:

☐ Drug Impaired
☐ Absent
☐ Alcohol Impaired
☐ Asleep
☐ Distracted
☐ Impaired by illness
☒ Impaired by disability
☐ Other: Mother had impaired mobility.

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	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)

LDSS Response

Following the receipt of the report, ACS interviewed relevant collateral contacts, including: the hospital nurse, MGF, LE, and ME. ACS did not interview EMS or the ER physician. ACS interviewed the parents and also observed the dresser which was located in the bedroom.

According to the mother's account, on 6/30/15, the MGF took the child to the park since the mother had medical condition which affected her mobility. When the MGF and child returned to the home, the mother played with the child in the living room and then the child went to her room. The mother remained on the sofa in the living room. The mother could see the child's room from the sofa. The mother saw that the child open the bottom drawer to the dresser. The mother said the child usually opened the drawer to take out her blanket and play so she did not feel alarmed. She saw the child open the second drawer from the bottom and saw her lift her leg as if to climb. According to the mother, the child never did this before, she then told the child 'no'. The child looked at the mother and smiled and at that moment the mother saw the dresser falling forward towards the child. The mother called out to the MGF to obtain his assistance but by the time the MGF got to the room the dresser was already on top of the child. At the time of the incident, the MGF was in the kitchen. The mother said the child was face down so she turned her over. The mother called 911 for assistance and performed CPR on the child. The mother said the child still had a pulse but not responsive. She saw that the child's lips turned blue. EMS arrived and transported the child to the hospital.

The father was at work at the time of the incident. He became aware of the incident after the mother contacted him by telephone and informed him that the child had been transported to the hospital. The father returned to the home to get his car and observed the police were on the scene.

ACS' staff conducted a reenactment based on the mother's account of the incident. This reenactment reflected that while sitting on the sofa in the living room, the mother would have been able to observe the child and the dresser in the bedroom. The Specialist observed the dresser was light brown and about five feet tall with five drawers. There was clothing in the drawers. The father informed ACS that the items on top of the dresser were a lamp, picture frame, and a small plant. The Specialist saw the lamp and clothing on the floor inches away from the child's toddler bed. The documentation did not reflect the dresser's weight was obtained.

ACS contacted LE who said there was no criminality therefore there was no District Attorney involvement. On 7/22/15, ACS established contact with the ME who reported that the cause of death was blunt impact to the head and the manner of death was an accident.

During the interview with the ACS staff, the MGF said the child went to her room and he went to the kitchen. The mother had previously sustained an injury which resulted in her limited mobility. The MGF said the mother yelled asking him to stop the child. He responded to the child's room and saw the dresser on top of her. He lifted the dresser off of the child and observed she was unconscious. He said the mother called 911 and began CPR. EMS arrived and directed him go to the other room which he did. EMS then transported the child to the hospital.

On 8/4/15, ACS unsubstantiated the allegations of DOA/Fatality, IG and LS of the child on the basis that the ME listed the cause of death as blunt impact to the head and the manner of death was an accident. ACS noted there was no credible evidence to suggest the parents failed to provide adequate guardianship to the child. The father was at work at the time of the incident. There was no credible evidence found that suggested the mother failed to provide adequate supervision. The mother was unable to stop the dresser from falling on top of the child.

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: 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 NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
021061 - Deceased Child, Female, 2 Yrs	021062 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
021061 - Deceased Child, Female, 2 Yrs	021062 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
021061 - Deceased Child, Female, 2 Yrs	021063 - Father, Male, 32 Year(s)	DOA / Fatality	Unsubstantiated
021061 - Deceased Child, Female, 2 Yrs	021063 - Father, Male, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
021061 - Deceased Child, Female, 2 Yrs	021062 - Mother, Female, 29 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐

First Responders	☐	☒	☐	☐
Other	☐	☒	☐	☐
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 case documentation did not reflect that first responders such as EMS were contacted regarding the incident.

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	☐	☐	☐	☐	☐	☒	☐

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.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The Specialist offered Bereavement Services to the family but the family declined.

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? 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/03/2015	5323 - Deceased Child on Report, Female, 2 Years	5324 - Day Care Provider, Female, 36 Years	Lack of Supervision	Indicated	Yes
	5323 - Deceased Child on Report, Female, 2 Years	5325 - Day Care Provider, Female, 46 Years	Lack of Supervision	Indicated	
	5323 - Deceased Child on Report, Female, 2 Years	5326 - Day Care Provider, Female, 30 Years	Lack of Supervision	Indicated	

Report Summary:
The 4/3/15 SCR report alleged on 4/3/15, the unknown named three-year-old child was locked outside the daycare facility left unattended by staff for several minutes.

Determination: Indicated

Date of Determination: 05/11/2015

Basis for Determination:
The Specialist found credible evidence to substantiate. The reported child walked out of the daycare while in the care of the three subject teachers. All three staff teachers reported to the Specialist that they were unaware that the child had left the daycare until she was found on the street by herself and returned to the daycare by a passerby. The child informed the Specialist that she was looking for her father. The Department of Health (DOH) suspended the license of the daycare pending an Oath Hearing and submission of a safety plan. The DOH's investigation also found violations.

OCFS Review Results:
The investigation was begun timely. On 4/3/15, the Specialist met with the New York City DOH inspectors who said a decision was made to suspend the daycare license and close the daycare immediately. DOH said they did find that the reported child was found outside of the DC on the street by herself with the DC staff unaware she was outside. ACS interviewed the parents of non-reported children. The mother was interviewed; however, documentation did not reflect the child's father was interviewed. CONNECTIONS reflected that the subjects and the mother were provided with the Notice of Existence (NOE) and Notice of Indication (NOI); however, the father of child was not provided these documents.

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

Issue:
Failure to provide notice of report

Summary:
CONNECTIONS reflected that the subjects and the mother were provided with the Notice of Existence (NOE); however, the father of child was not provided this document.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

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.

Issue:
Provision of Notice of Indication

Summary:
CONNECTIONS reflected that the subjects and the mother were provided with the Notice of Indication (NOI); however, the father of child was not provided this document.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)
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.

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

The parents were not known to the SCR or ACS as subjects.

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 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