Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-17-011

Prepared by: New York State Office of Children & Family Services

Issue Date: Aug 25, 2017

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
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-Other	
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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Clinton
Gender: Male
Date of Death: 09/26/2010
Initial Date OCFS Notified: 04/01/2017

Presenting Information

An SCR report was received on 4/1/2017 with allegations of LS, IG, DOA/Fatality and C/T/S against the SM regarding the SC. The report alleged on 9/25/2010 the SM placed the 5-month-old SC in a round circular chair sitting up with a bottle propped in his mouth. The SM also wrapped the SC tightly to prevent him from moving. The SM then went to bed leaving the SC unsupervised. Later that night the SM checked on the SC and gave him a bottle of water and changed his diaper, but left the SC propped up in the chair and returned to bed. In the morning the SF found the SC still sitting upright in the chair, unresponsive and blue. The SF called 911 and attempted CPR. EMS responded and were unable to save the SC. This was a fatality previously reported and investigated by Clinton County Department of Social Services (CCDSS).

Executive Summary

This fatality report concerns the death of a 5-month-old male that occurred on 9/26/2010. The death of the SC was initially investigated by CCDSS at the time of the fatal incident. On 4/1/2017 an SCR report was again received by CCDSS regarding the death of the SC. The report alleged the SM wrapped the SC up tightly and placed him in a chair. It was further alleged the SM propped him sitting up, with a bottle in his mouth in the downstairs of the home, while the SM and SF were sleeping upstairs in the home with the SS. The SF and SM awoke to find the SC unresponsive. The report also alleged the SF had a role in failing to provide adequate care to the SC and the SS. There was no new information regarding the death of the SC provided in the 4/1/2017 SCR report.

CCDSS began a new investigation into the death of the SC on 4/1/2017. CCDSS contacted the source, LE, the DA and appropriate collaterals. CCDSS also interviewed the SM and SF and saw the SS to assess her safety. CCDSS pulled all information forward from the previous investigation.

There was one SS alive at the time of the SC's death. As a result of the 2010 fatality investigation, the SS was removed from the SM and SF and CCDSS filed a neglect petition against both parents. The SS was placed in kinship foster care with the PGM for several months, and eventually the Family Court awarded the PGM custody of the SS. The SS remains in the custody of the PGM. CCDSS spoke with the SS and PGM at their home. The SF had regular unsupervised visitation with the SS and the SM had regular supervised visitation. There were no concerns regarding the safety of the SS. The SM gave birth to a baby boy (SS1) during the course of the 2017 investigation. CCDSS assessed the safety of the new child as well. CCDSS provided safe sleep education to the SM and BF.

CCDSS asked LE if they wanted to be involved in the new investigation and LE declined. As a result of the previous investigation of LE into the death of the SC, the SM was convicted of criminally negligent homicide and sentenced to 1-3 years in prison. The SM served approximately 1-year of the prison term and was paroled. The SM was re-confined to serve out her sentencing as the result of a violation of parole. The SF was convicted of endangering the welfare of a child.

The ME provided CCDSS with the final autopsy report at the conclusion of the 2010 investigation. The SC's cause and manner of death were undetermined.

CCDSS appropriately substantiated the allegations of IG, LS and DOA/Fatality against the SM regarding the SC. CCDSS also appropriately added and substantiated these same allegations against the SF regarding the SC. They also substantiated

the allegation of IG against SM and SF regarding the SS that was alive at the time of the fatality. There was an allegation of C/T/S against the SM regarding the SC in the 2017 report that was not listed in the 2010 report. CCDSS appropriately unsubstantiated this allegation because there was no new information discovered to substantiate. The determinations made by CCDSS in the 2017 investigation mirrored the 2010 investigation. CCDSS found evidence in the 2010 investigation that the SM and SF often left the SC and the SS sleeping unattended with propped bottles, despite CCDSS' advice against this practice and the education they provided on safe sleep.

As a result of the SM giving birth to a child, CCDSS offered her and the BF of SS1 Preventive Services in addition to parent education. The SM and BF accepted these services and were working with CCDSS at the time of this 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?** 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

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 closing of 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: 09/26/2010 **Time of Death:** 06:23 AM

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

County where fatality incident occurred: Clinton
Was 911 or local emergency number called? Yes
Time of Call: 09:23 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? No - but needed
At time of incident supervisor was:

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Month(s)

LDSS Response

CCDSS began an investigation on 4/1/2017 after receiving the SCR report regarding the death of the SC. CCDSS contacted the source and reviewed CPS history, including the historical fatality investigation. CCDSS interviewed the SM and SF regarding the circumstances of the fatality. CCDSS also visited the SS at the PGM's home and determined she was safe. The PGM reported she has had custody of the SS since soon after the fatality. CCDSS learned that the SM has supervised visits with the SS every other weekend and the SF visits frequently and is not supervised. CCDSS also spoke to various medical and LE professionals during the 2010 investigation. CCDSS also spoke with collaterals that provided services to the SM and SF since the death of the SC.

CCDSS did not find any new information about the fatality in their interviews and review of the evidence and records from the previous investigation. In both investigations the SM and SF reported the same details regarding the time leading up to the fatality. The SF found the SC unresponsive on the downstairs sofa the morning of 9/26/2010. The SF had not seen the SC since the night before when he went to sleep upstairs. The SF slept in his bedroom upstairs and the SS slept in her crib, also upstairs. The SM had put the SC to sleep at 9:30pm on 9/25/2010, in a pack and play in the downstairs living area of the home. The SM then joined the SF in the bed to sleep. The SM awoke at 12:30am to the SC crying downstairs and she

went downstairs to feed him. The SM then placed the SC in a chair with blankets all around him. After staying downstairs for about half an hour, the SM propped a bottle with the SC and returned upstairs, and went back to sleep. When the SF found the SC unresponsive, he called for the mother and she called 911. In the time before EMS arrived, the SF attempted to resuscitate the SC. EMS and LE arrived and were unable to save the life of the SC.

The SC had no visible marks or bruises. First responders stated the SC was found with his chin resting against his chest and he had a mark that corresponded with this position. The SM and SF had been advised numerous times about the dangers of propping the bottle of the SC and SS. They had also been educated on safe sleep previously. The SM and SF denied drug or alcohol use the evening of the fatal incident, but admitted to previous drug use.

CCDSS made appropriate referrals for grief counseling at the time of the fatality. The parents were not cooperative with CCDSS initial efforts to provide services in an effort to reunite the SS to their custody. CCDSS learned the SF and SM had parted ways after the fatality. The SM was in and out of incarceration and struggled with drug and alcohol use. The SF was on probation and also had struggles with alcohol and drug use. The SM and SF had both participated in parenting classes and the agency recommended Substance Abuse and MH services.

CCDSS learned that the SM was pregnant during the 2017 investigation. There was an SCR report made on 5/24/2017 after the SM gave birth to the SS1. CCDSS had already spoken with the SM and the BF of the SS1 about accepting Preventive Services. The SM and BF accepted the services and a Preventive case was opened.

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: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
038721 - Deceased Child, Male, 5 Mons	038722 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
038721 - Deceased Child, Male, 5 Mons	038723 - Father, Male, 28 Year(s)	Lack of Supervision	Substantiated
038721 - Deceased Child, Male, 5 Mons	038722 - Mother, Female, 20 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
038721 - Deceased Child, Male, 5 Mons	038722 - Mother, Female, 20 Year(s)	Lack of Supervision	Substantiated
038721 - Deceased Child, Male, 5 Mons	038722 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
038721 - Deceased Child, Male, 5 Mons	038723 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated

038721 - Deceased Child, Male, 5 Mons	038723 - Father, Male, 28 Year(s)	DOA / Fatality	Substantiated
038724 - Sibling, Female, 5 Month(s)	038723 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
038724 - Sibling, Female, 5 Month(s)	038722 - Mother, Female, 20 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
There were no SS in the household of the SF or SM at the time of the 2017 fatality report. The SS resided with her PGM and the SM and SF have arranged visits with her. During the 2017 investigation the SM had another child. CCDSS offered preventive services and the SM and her husband are working with CCDSS on an ongoing basis.

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:**
10/20/2010	Adjudicated Neglected	Care/Custody to Local Social Services District
Respondent:	038722 Mother Female 20 Year(s)	
Comments:	The SS was later released to the custody of the PGM on 10/15/2012.	

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
10/20/2010	Adjudicated Neglected	Care/Custody to Local Social Services District
Respondent:	038723 Father Male 28 Year(s)	
Comments:	The SS was later released to the custody of the PGM on 10/15/2012.	

Criminal Charge: Manslaughter **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
08/17/2011	SM	Unknown	plead guilty
Comments:	The SM was charged in relation to the death of the SC when the death occurred. The charge was reduced to criminally negligent homicide and the SM took a plea bargain. The SM served a sentence in prison as a result.		

Criminal Charge: Endangering the welfare of a child **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
08/17/2011	SM	Unknown	dismissed
Comments:	The SM was charged in relation to the death of the SC when the death occurred. The SM served a sentence in prison as a result of other charges associated with the death and a plea bargain accepted.		

Criminal Charge: Endangering the welfare of a child **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
08/17/2011	SF	Unknown	guilty
Comments:	The SF was on probation at the time of this charge and was sentenced to an additional 3 years on probation. The SF additionally spent 4 weekends in jail.		

Have any Orders of Protection been issued? Yes

From: 02/17/2011	To: 09/17/2011

Explain:
The SM and SF were ordered to have drug/alcohol evaluations in addition to submitting to random drug screens. The SM and SF were also ordered to work with CCDSS.

Services Provided to the Family in Response to the Fatality

Services	Provided	Offered,	Offered,	Needed	Needed	N/A	CDR

	After Death	but Refused	Unknown if Used	but not Offered	but Unavaliable		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? Yes
Explain:
The SS was removed and placed with the PGM.

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? 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 ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ 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 in NYS within three years prior to the fatality.

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

SCR report received on 1/9/2011 with allegations of II and IG against the PGM regarding the SS. The allegations were Unsub on 3/4/2011.

SCR report received on 9/26/2010 with allegations of IG, DOA/Fatality and LS against the SM and SF regarding the SC and an allegation of IG against both parents regarding the SS. All allegations were Sub on 1/19/2011.

SCR report received on 7/26/2010 with allegations of IG against the SM and SF regarding the SC and SS. The allegation was Sub on 9/20/2010.

Known CPS History Outside of NYS

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

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐ Yes ☒ No

Preventive Services History

Following the death of the SC, CCDSS filed a neglect petition for the SS on 10/20/2010 and this resulted in the the SS living with a friend of the SM and SF, as agreed upon by CCDSS and both parents. On 11/29/2010 the PGM was given temporary custody and on 1/20/2011 the PGM was awarded Article 6 custody. On that day the SM and SF were adjudicated neglectful at a fact finding hearing. CCDSS worked with the SM and SF regarding services they were ordered to participate in. The SM and SF had visits with the SS during this time.

On 03/15/2011 the SS was removed from the SM and SF and the foster care case began. The PGM chose to become a certified foster parent and the child remained in her home although she was in the care and custody of the Commissioner. The case remained open and CCDSS continued to work with the SM and SF with the goal of the SS returning to their care. On 10/15/2012 the SS was released to the custody of the PGM and the foster care case closed. The SM and SF continued to have visits supervised by the PGM with the SS.

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