NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-15-010 **Prepared by: Rochester Regional Office**

Issue Date: 8/28/2015

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
Age: 3 month(s)
Jurisdiction: Chemung
Gender: Female
Date of Death: 03/20/2015
Initial Date OCFS Notified: 03/20/2015

Presenting Information

On 3/20/15 an SCR report was received by Chemung County Department of Social Services (CCDSS), the report alleged that on 3/19/15 at 11:30pm, the biological father (BF) went to bed and was co-sleeping with the subject child (SC). Around 3:00am, the biological mother (BM) found the SC unresponsive. The SC died and the cause of death was unknown at that time.

Executive Summary

This fatality report concerns the death of a three-month-old female that occurred on 3/20/15. The preliminary autopsy report was received on 4/8/15 and stated the cause and manner of death were "pending". CCDSS received an SCR report regarding the death of the SC.

The parents consistently reported to CCDSS and first responders that the SC was put on the parents bed to sleep on his back around 10:00PM. The BF went to bed with the SC between 11:00PM-12:00AM. The father was co-sleeping with the SC who was on the left side of the bed. The SC had a sheet covering her body and her head was uncovered. The BF stated he moved the SC closer to him so the BM could get into bed. The BM had fallen asleep on the couch. At 2:50AM, the BM awoke and went into her bedroom. The BM found the BF was lying on his side with his arm around the SC. The BM picked up SC to put her in her bassinet when she noticed a foamy nasal mucus ball on the SC's lip and noticed the SC was cold. The SC had a watery bloody substance coming out of the SC's nose and her chest was covered with the substance. The BM started doing chest compressions and yelled for the BF to call 911.

Per the BF, he drank six to eight beers between 5-9:30PM and the BM reported that she had one drink before bed. Law Enforcement (LE) completed a Blood Alcohol Content on the BF who had a .03% at 6:00am on 3/20/15. According to Law Enforcement (LE) who reported that there were no arrests at that time. LE observed marijuana paraphernalia and beer cans in the home. CCDSS addressed the concern and recommended the parents receive a drug/alcohol evaluation. CCDSS provided the family with information regarding bereavement services. At the time of this report the ME report is pending.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Casework activities was commensurate with case circumstances.

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: 03/20/2015 **Time of Death:** 03:25 AM

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

County where fatality incident occurred: CHEMUNG
Was 911 or local emergency number called? Yes
Time of Call: 02:50 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was:
☐ Drug Impaired ☐ Absent

☒ Alcohol Impaired
☐ Distracted
☐ Impaired by disability
☒ Asleep
☐ Impaired by illness
☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 01

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	10 Year(s)

LDSS Response

On 3/20/15 CCDSS received a report from the SCR naming the SC as the maltreated child with the mother, father as subjects of the report with allegations of DOA/F and IG.

The parents consistently reported to CCDSS and first responders that the biological father was co-sleeping with the SC on the left side of the bed while the biological mother (BM) was taking care of the surviving sibling. When the BM checked on the SC she found her unresponsive, BM immediately called 911. Biological parents provided no explanation for the SC's death.

On 3/20/15, Chemung County Department of Social Services (CCDSS) Case worker (CW) contacted Law Enforcement (LE) who reported that there were no arrests at that time. A joint investigation was initiated. Bio parents were interviewed in regards to SC death. During the interview CCDSS documented that on 3/19/15 BF, BM, SC, and SS were home during the evening. BF reported that he drank 6 beers between 5-10PM prior to going to bed BM reported that she was aware of BF alcohol consumption that night. BF confirmed that on average he consumed this amount of alcohol on a nightly basis. BM reported that BF went to bed at 11:00PM.

BM stated that SC slept in the middle of the bed with a large number of pillows around her to prevent her from rolling. BM stated that she woke up at 2:50AM and went into the bedroom where she noted that BF was laying on his side with his arm around the SC. BM stated she picked up SC to put her in her bassinet when she noticed a foam snot ball on the SC's lip. BM stated she turned on the light to see what this was, and noticed the SC was cold. BM stated she started doing chest compressions and yelled at BF to call 911. BM stated that BF had a six pack of beer and BM had one drink of alcohol prior to bed.

BF reported that he went to bed between 11:00PM-12:00AM, the SC had already been sleeping in the bed after BM put her down. BF reported when he came to bed he felt the chest of SC and SC was breathing. SC had a sheet covering her body and her head was uncovered. BF stated that he moved SC closer to him so BM could get into bed. BF reported that BM turned the light on and yelled for him to call 911 and begin CPR.

During the course of the investigation BF denied being intoxicated at the time of the SC death, however, LE completed a Blood Alcohol Content (BAC) and reported that BF BAC was .03 when he was tested at 6AM the morning following the SC death. Information from LE indicated that BF was still under the influence of alcohol at that time and would have been more intoxicated 6 hours prior to BF co-sleeping with SC.

During CCDSS assessment of the home environment the basement was completely filled with empty beer cans and additionally the police discovered a bag of marijuana. BF subsequently admitted to using marijuana in the days prior to the SC death. During interview with the SS she confirmed alcohol use by her BF. Although ME report remains pending at this time information received by ME reported that there is no medical explanation for SC death and confirmed all tests for infection/viruses were negative. ME also reported that the SC death most likely occurred from positional asphyxiation; possibly the father rolling over on SC. The final autopsy report remains pending. Services were offered to the family and accepted by BM for grief counselling, BF declined to engage in any services.

On 5/28/15 CCDSS appropriately indicated allegations of DOA/F, PDRG, and IG against BF due to some creditable evidence that BF's alcohol consumption while caring for the SC as well as co-sleeping with SC contributed to the death. BM was also indicated for IG as she was aware of BF being under the influence of alcohol and allowed the SC to co-sleep with BF. CCDSS should be commended for the work on this investigation.

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)?Yes
Comments: CCDSS conducted a MDT in regards to the fatality investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
017601 - Deceased Child, Female, 3 Mons	017604 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
017601 - Deceased Child, Female, 3 Mons	017603 - Father, Male, 34 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
017601 - Deceased Child, Female, 3 Mons	017603 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
017601 - Deceased Child, Female, 3 Mons	017603 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated

019201 - Sibling, Female, 10 Year(s)	017604 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
019201 - Sibling, Female, 10 Year(s)	017603 - Father, Male, 34 Year(s)	Parents Drug / Alcohol Misuse	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 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? 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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BF declined services offered by CCDSS. The BM was in agreement and accepted services for grief counseling and parenting.

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? No

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

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

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