Child Fatality Report

Report Identification Number: SY-16-055

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

Issue Date: Apr 11, 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	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Broome
Gender: Male
Date of Death: 11/01/2016
Initial Date OCFS Notified: 11/01/2016

Presenting Information

On 11/01/16 an SCR report was received by Broome County Department of Social Services (BCDSS) regarding the death of the 4-month-old male SC. A duplicate report was received on the same day. The allegations were that on 11/01/16 authorities responded to the home as a result of the 4-month-old SC being found unresponsive and not breathing in the SF's bed. The SC had blood on his forehead and face. The SC slept in bed with the SF and was believed to be suffocated during the night. The SC was believed to be an otherwise healthy baby. The SF was the only adult in the home at the time of the incident.

Executive Summary

On 11/01/2016 BCDSS received an SCR report with allegations of DOA/Fatality and IG against the SF as the four-month-old male SC was found unresponsive in the SF's bed. SM, SF and SC recently moved from NYC to Broome County and were staying with the PGM and her four children (PAs ages 16, 13, 2 and 8 months). BCDSS spoke with the SM on the phone who said she fed the SC about 4.5 oz. at 2:25 AM on 11/1/2016, swaddled the SC and put him on a boppy pillow on the adult bed. She then took a cab to the bus station where she took the 3:05 AM bus to NYC to visit family. The SM later received a call from family informing her of the incident and she was on a bus on her way back home when speaking to the caseworker.

BCDSS observed the SC's body at Wilson Hospital and spoke with LE. LE reported that when they arrived at the home the SC had dried blood by his mouth. The paramedics had the SC on the bathroom floor attempting to give CPR. The SF admitted to LE that the SC was sleeping in bed with him. The SF reported that the SC was fidgety when he arrived back upstairs from walking the SM down to her cab. He made a 6oz bottle, propped the bottle and the SC ate about 2 oz. He burped the SC and put the SC to bed with him since SM was not home, although the SC usually sleeps in a bassinet. He said he woke about 6:30 or 7:00 am and the SC had dried blood on his mouth. He went to wipe it off and he was cold. He woke his sisters and called 911. They put the SC on the bathroom floor and started CPR. The SF denied that the SC had been sick. The SF was so distraught upon arriving at the ER that he required a mental health evaluation.

The CW interviewed the 16-year-old PA who stated that she was woken up by SF when he came running into her room for help and saying that the baby was not breathing. She tried to call her mother, called her grandmother, and then called 911. She showed the CW photos of the SC in his bouncy seat that she had taken around 12:30 am that morning. In the photos the SC appeared healthy, clean and well cared for, with no injuries visible. The CW attempted to interview the 13-year old PA. She was home for the incident, although she was too upset to be interviewed. The 2-year-old and 8-month-old PAs were observed and were assessed to be safe and the home was observed to have no safety hazards. The SM and SF's bedroom was observed where the incident occurred. The PGM was interviewed and stated that she and her 8-month-old were not home for the incident as they spent the night at a friend's home. BCDSS went over safe sleep with the PGM in regard to the 8-month-old PA, and a safe sleep environment was observed for that child. All family members were provided with information on grief counseling.

The provisional autopsy report ruled the death to be asphyxia due to unsafe sleep environment co-sleeping with adult in adult sized bed, overlay. The report found the SC to be large for his age (97th percentile), and found no evidence of

congenital defects, disease or injury. BCDSS was later informed that the toxicology results showed the SC was Strep B positive, although there was no evidence that it contributed to the SC's death.

The SM and SF returned to NYC within a week of the incident. BCDSS made numerous attempts to locate the parents and were able to speak to them on 02/10/2017. The CW learned that the SM and SF were receiving bereavement counseling in NYC.

BCDSS accurately indicated the report as there was credible evidence that the SF and SM were informed on multiple occasions of safe sleep recommendations as well as the aggravating circumstances being present of heavy blankets and pillows on the bed and the size of the sleep surface with the SF being so large compared to the small infant SC, both creating an unsafe condition. The report was closed as the parents moved out of jurisdiction, had no surviving children and there were no identified service needs for the PGM and her children.

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:
BCDSS obtained sufficient information to make the determination that there were no safety factors present during 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 case was appropriately indicated and closed. The SM and SF retuned to NYC and had no surviving children. The PGM was not in need of services for her and her children.

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: 11/01/2016 **Time of Death:** Unknown

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

County where fatality incident occurred: BROOME
Was 911 or local emergency number called? Yes
Time of Call: 07:13 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
How long before incident was the child last seen by caretaker? 4 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not impaired.

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	Aunt/Uncle	No Role	Female	13 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	16 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	8 Month(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	2 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	36 Year(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)

LDSS Response

On 11/01/16 an SCR report was received by BCDSS regarding the death of the four-month-old male SC. A duplicate report was received on the same day. Upon receiving the report BCDSS immediately conducted a home visit at the PGM's home where the SM, SF and SC were temporarily staying. It was learned that the family had just moved from NYC and were staying with PGM until they found their own place. The CW spoke to LE who were still at the home. The CW observed the SM and SF's bedroom from the doorway as they were not able to enter due to LE request. The adult bed was observed where the incident occurred, which contained a lot of comforters and blankets tucked on the bed. A bassinet was observed at the foot of the adult bed which contained blankets. There was a slight smell of marijuana in the home; otherwise there were no safety hazards observed. The CW interviewed the 16-year-old PA and observed the two-year-old PA, assessing them to be safe. BCDSS conducted a field visit at Wilson Hospital and observed the SC's body and spoke with LE. They spoke to the SF, SM, MU, MGM and family friend. It was learned that the SC slept in bed with the SF and was believed to be suffocated during the night. The SF found the SC unresponsive when he woke up around 6:30 or 7:00 am and saw dried blood on the SC's mouth. The SF took the death very hard and received a mental health evaluation while at the hospital. The CW contacted a local resource that family members could utilize for housing while they were in town for support. BCDSS went to school to speak to the 13-year-old PA and assess her safety. BCDSS then returned to the PGM's home where they observed the 13-year-old, two-year-old and eight-month-old PAs who were all observed to be safe. All family members were distraught over the incident so BCDSS provided resources for grief counseling and reiterated the importance of contacting them for support. BCDSS went over safe sleep with the PGM in regard to the eight-month-old PA and stressed the importance of no items in the crib or pack n play. Three days after the incident the SM informed BCDSS that she moved back to NYC and was too distraught to provide her new address. BCDSS attempted to contact the SF to conduct a re-enactment but they were informed that the SF also moved to NYC to be with the SM. BCDSS was unable to locate the SM and SF in NYC in order to follow up with them, until almost three months later. When BCDSS received a valid phone number they followed up with the SM and SF about the incident and verified that they were receiving local bereavement counseling services.

BCDSS went above and beyond to ensure that they conducted a thorough and complete investigation. They made appropriate assessments of safety for the four PAs. BCDSS conducted criminal background checks and contacted child support in an attempt to locate the BFs for the PAs. Medical records were received and reviewed for the PAs. When contradictory information was received, BCDSS contacted all necessary collaterals in order to clarify the cause of death. They reviewed medical records from the SC's pediatrician in NYC in order to verify that the SM and SF were informed of safe sleep recommendations at the hospital when the SC was born and at several doctor's appointments. The autopsy report ruled the death to be asphyxia due to unsafe sleep environment, co-sleeping with adult in adult sized bed, overlay. After further testing it was determined that the SC was positive for Strep B infection, although displayed no signs of infection and was otherwise healthy.

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: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: The investigation adhered to approved protocols for joint 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
031962 - Deceased Child, Male, 4 Mons	031964 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
031962 - Deceased Child, Male, 4 Mons	031964 - Father, Male, 21 Year(s)	DOA / Fatality	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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: No removal was required in regard to the surviving children.				

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	☐	☐	☒	☐	☐	☐	☐

Other, specify: Housing for relatives

Additional information, if necessary:
BCDSS contacted a local resource that family members could utilize for housing that were visiting from out of town. It's unknown if this service was utilized. BCDSS offered resources for grief counseling to the SM, SF and PGM. The SM and SF enrolled in bereavement counseling after returning to NYC.

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:
BCDSS immediately educated the PGM on safe sleep and the recommended guidelines in regard to her eight-month-old infant. BCDSS provided a list of resources for grief counseling to the PGM for her four children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BCDSS provided the SM, SF and PGM with a list of resources for grief counseling. BCDSS contacted a local resource

that family members could utilize for housing while visiting from out of town.

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? 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 in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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.

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