NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-14-033 **Prepared by: Buffalo Regional Office**

Issue Date: 9/24/2015

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: 2 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 12/04/2014
Initial Date OCFS Notified: 12/04/2014

Presenting Information

On 12/3/14, the SM and SF went to sleep with the two-month-old subject child in bed with them. The SM checked on the SC around midnight. While the SF was asleep he rolled over on top of the SC and suffocated the SC to death. When the SM awoke she found the SC face down in the bed and the SF was lying on top of the infant. It was unknown how long the SF was on top of the SC. The SC had blood pooled in his face and chest area. The SC's left arm was straight up in the air, rigormortis had set in and he was cool to the touch. PGGF was also in the home at the time of the death.

Executive Summary

The SCR report was made on 12/4/14 when the SC was found face down not breathing on the parent's bed. The allegations of DOA/Fatality and Inadequate Guardianship were against the SM and SF, age 18 and 16, respectively. The medical examiners report listed the cause of death as positional asphyxiation and the manner of death as accidental. The SC also had mild and acute bronchitis but of insufficient severity to cause his death. There was no trauma to the SC and he was considered to be a normal infant. There were children listed on the report that lived with the PGM next door to the PGGF. These children were not there when the SC died. Therefore, there were no surviving siblings. The caseworker went out to the home on the day of the report after contacting the source and law enforcement. The CW spoke to the PGGF, the SF and the SM. The SM stated that about 8 pm. on 12/3/14 she fed the SC a bottle and laid down on the bed with him on her chest. The mother stated she was burping him. The last time the mother looked at her phone it was 12:40 a.m. The SM stated that she fell asleep with the SC on her chest. The SM stated that she woke up with the SF next to her. She had a headache so she propped the SC on a pillow next to the sleeping SF and went to sleep in the bedroom across the hall. When she awoke at 6:50 am the SC was lying diagonal near the SF's knee, on top of the blanket, face down with his head turned slightly and not breathing. The SM stated she started screaming and woke the SF up by shaking him. The SM brought the SC down stairs and called 911 and gave the phone to the PGGF. The SF tried to give the SC mouth to mouth but fluid came out of the SC nose. The SF stated that when he went to bed the SM and the SC were asleep. He climbed into bed and didn't think about moving the infant to the bassinet. Both the SM and SF denied co-sleeping with the SC before that night. The SF admitted to smoking marijuana the night of 12/3/14. In the bassinet was just a baby blanket which they used to swaddle the SC in. The PGGF stated that the SC was stiff, pale and cold at the time the SM brought the child downstairs. EMS arrived and stated that rigor mortis had already set in. The caseworker contacted all appropriate collaterals police, EMS, Medical Examiner's office, etc. The investigation was completed on 2/2/15. The allegations on DOA/Fatality and IG were substantiated against both parents. Both parents knew that the SC was in bed with them but failed to put him into the bassinet. The father admitted to smoking marijuana the night before the infant's death. There were no surviving sibling, therefore, the case was indicated and closed. The caseworker gave the parents information on safe sleep as well as a referral to grief counseling and substance abuse treatment. The caseworker went out on the case in a timely manner, the notes are of good quality and detailed. The indication was appropriate as the parents had a bassinet that was used for the SC and failed to make the appropriate safe sleeping arrangements which caused the SC death.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

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

Explain:
All the allegations were addressed and the case was indicated and closed appropriately

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 investigation was completed in a timely manner. The report was indicated and closed appropriately

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: 12/04/2014 **Time of Death:** Unknown

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

County where fatality incident occurred: ERIE
Was 911 or local emergency number called? Yes
Time of Call: 06:56 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	☐ Asleep
☐ Distracted	☐ Impaired by illness
☐ Impaired by disability	☐ Other:

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	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	16 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	60 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)

LDSS Response

The caseworker went out the day of the report and talked to all the parties. All collaterals were contacted . All history was reviewed. The investigation was done jointly with the police. The caseworker spoke to all necessary collaterals, Medical Examiner's office, pediatrician and school. The caseworker engaged the parents and the PGGF. All necessary referrals were made.

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

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
019161 - Deceased Child, Male, 2 Mons	019163 - Father, Male, 16 Year(s)	DOA / Fatality	Substantiated
019161 - Deceased Child, Male, 2 Mons	019163 - Father, Male, 16 Year(s)	Inadequate Guardianship	Substantiated
019161 - Deceased Child, Male, 2 Mons	019241 - Mother, Female, 18 Year(s)	DOA / Fatality	Substantiated
019161 - Deceased Child, Male, 2 Mons	019241 - Mother, Female, 18 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/05/2014	4222 - Father, Male, 16 Years	4221 - Grandparent, Male, 60 Years	Sexual Abuse	Indicated	No
	4222 - Father, Male, 16 Years	4223 - Mother, Female, 18 Years	Sexual Abuse	Indicated	

Report Summary:
For the past year the PGGF had allowed the SF, age 16, to share a bed with the SM, age 18. The parents engaged in sexual intercourse and the SF was not of the age of consent. The sexual intercourse led to the birth of the SC.

Determination: Indicated | **Date of Determination:** 02/02/2015

Basis for Determination:
The allegations of sexual abuse and IG were substantiated against the PGGF. The PGGF allowed the SM, age 18 to share a bed with the SF, age 16. The SM and SF had the SC in Spetember 2014. The SM continues to reside in the home. She and the SF continue to share a bed. Case was indicated and closed with no services. The caseworker did everything in a timely manner and interviewed all the parties and appropriate collaterals, such as school and the Buffalo Police Dept. The SF was given a referral packet for substance abuse due to his suspension from school for smoking marijuana.

OCFS Review Results:
The investigation met all statutory regulations

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

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.

Known CPS History Outside of NYS

none known

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