Child Fatality Report

Report Identification Number: SY-19-022

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

Issue Date: Nov 01, 2019

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	OA-Other Adult	
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
CPS-Child Protective Services		
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
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 16 day(s)
Jurisdiction: Tioga
Gender: Male
Date of Death: 05/09/2019
Initial Date OCFS Notified: 05/09/2019

Presenting Information

An SCR report alleged around 7:19 AM on 5/9/2019, a 911 call was made regarding a two-week-old infant who was not breathing. Emergency services responded to the home and attempted CPR, but the infant was pronounced deceased shortly thereafter. Since there was no explanation for his death at the time of the report, the adults with whom he resided were made alleged subjects. This included his parents, grandparents, uncle, and an unrelated home member.

Executive Summary

This fatality report concerns a 16-day-old infant whose death was reported to the SCR and investigated jointly by Tioga County Department of Social Services (TCDSS) and the Waverly Police Department. It was alleged the six familial adults in the infant's home, including his parents, were responsible for his unexplained death.

Investigators considered whether an unsafe sleeping environment contributed to the infant's death. The parents reported the infant was placed to sleep on his back in a portable crib in the early morning hours of 5/9/2019 with a blanket on the lower half of his body; a stuffed animal was also found in the crib. They said he slept in the living room while they slept in a bedroom. A household member claimed the parents shared their bed with the baby the night of the incident; whether this was accurate remained unknown, as the parents and other adults maintained the sleeping arrangements were separate. Despite this inconsistency, the coroner reported that even if there was bed-sharing, it had no bearing on the infant's death given the determination that the cause of death was medical in nature. The coroner shared there were no fibers in the infant's nasal passages or on his throat or fingers, indicating to him that bedding and/or blankets had not been near the infant's face. There were no arrests or criminal charges.

The final autopsy report revealed the manner of death was natural and the cause was bronchopneumonia. The parents and other family members reported the child had episodes of coughing, fever, and difficulty breathing; they noted having consulted these symptoms with the pediatrician who suggested over-the-counter remedies and follow-up at a scheduled well-child exam. Hospital and pediatrician records indicated no medical complications or concerns throughout his life, including during delivery; though asked, staff at the pediatrician's office did not confirm or deny the parents' outreach about medical symptoms.

The infant had one surviving sibling who was two years old. The children had the same mother, and the half-sibling lived out-of-state with his paternal relatives. TCDSS made considerable efforts to coordinate with Bradford County Children and Youth Services (CYS) in Pennsylvania to confirm the sibling's primary custodian and residence and assess his safety. Though TCDSS was unable to gather this information, the mother reported the sibling's paternal aunt was recently given custody after his father, his primary custodian moved out of state. She further stated the aunt was not allowing her to have visits given the death of the infant; however, TCDSS could not verify the information given the lack of response from Bradford County CYS despite TCDSS' many efforts to gather the necessary records. TCDSS attempted to verify whether the sibling was previously removed from the mother for protective concerns in Pennsylvania, though the barrier with information sharing on behalf of CYS left the question unanswered. Given there were no concerns revealed for the parents' care of the infant – regarding the circumstances of his death or otherwise – there were no concerns for the sibling, who was not in either adults' care.

Based on the medical findings concerning the infant's death, the allegations of inadequate guardianship and DOA/Fatality were unsubstantiated against the mother, father, maternal and paternal grandmothers, maternal uncle, and his girlfriend.

TCDSS paid for funeral expenses and referred the family to services. As there were no surviving children in the parents' immediate care and no areas of concern warranting further child welfare involvement, the investigation was closed.

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 activity was commensurate.

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:
TCDSS gathered the final autopsy report from the Coroner which indicated the cause of death was medical in nature; therefore, the determination 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: 05/09/2019 **Time of Death:** 08:23 AM

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

County where fatality incident occurred: Tioga
Was 911 or local emergency number called? Yes
Time of Call: 07:18 AM
Did EMS 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
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ Other:

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	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	16 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	50 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	29 Year(s)

LDSS Response

TCDSS promptly initiated the fatality investigation by informing the District Attorney's Office, coordinating with LE, and visiting the home. CPS, LE, and the Coroner met to discuss preliminary information and plan the investigation.

No other children resided in the infant's household with his parents, maternal and paternal grandmothers, maternal uncle, and uncle's girlfriend. Within 24 hours of the report, TCDSS learned from the mother that she had another child, age 2, who lived out of state but visited her home. Since TCDSS' initial protective concerns regarded the deceased child's unsafe sleeping environment, there were no immediate concerns that translated to the older sibling.

CPS and LE jointly interviewed the parents on separate occasions; they had similar accounts of events leading up to the fatality. TCDSS obtained statements from LE's interviews of the other adults in the home and did not note any concerns or discrepancies. The mother placed the child to sleep after 10PM on 5/8/2019 in a portable crib and said he awoke about two hours later, at which time she fed him. TCDSS learned the child was last seen alive shortly thereafter, sometime around 2AM when he woke for another feeding. The father was awake at that time, and after starting to feed him, he woke the mother to finish. The mother confirmed this but was unaware of the time. She said she placed him to sleep in the crib on his back after the feeding with a blanket pulled up to his chest. Around 7AM she awoke, noting he was blue and gasping for air. The household members awoke from the commotion and the paternal grandmother initiated CPR. The mother called the father and then 911.

Both parents described the child historically had episodes of abnormal breathing. Progress notes reflected the mother said the child occasionally "wouldn't breathe right," which began after he came home from the hospital; the father said the infant had difficulty breathing over the week prior. They noted it accompanied a cough and a fever on 5/8/19, for which they said they called the pediatrician's office and were directed to administer Tylenol and follow up at an appointment on 5/13/19. The pediatrician records indicated the infant was seen for a well child exam on 4/30/19 at one week old with no notable health concerns. The father mentioned he brought up the breathing concern at that visit and was told it was not an issue. Records received by TCDSS did not note whether any phone communication took place between the family and providers; attempts to speak directly with medical staff to verify was unsuccessful despite the legal coordination that TCDSS facilitated at the clinic staff's request.

Results from the autopsy report provided the basis for TCDSS to unfound the report against all subjects, as the child died of bronchopneumonia. TCDSS found no credible evidence to substantiate any concerns regarding the care of the child's medical condition – no evidence confirmed how long the child had the illness and whether any acts of omission or commission contributed to his demise.

TCDSS made many efforts to collect information from Bradford County CYS in Pennsylvania, as it was learned many of the alleged subjects had CPS history there, as did the surviving sibling. TCDSS learned some historical information through verbal communication but were not provided with written documentation despite numerous requests. Further, TCDSS did not receive requested documentation or information to verify the legality of the sibling's custody, including whether he had once been formerly removed from the mother, so TCDSS made efforts to contact the sibling's biological father and presumed custodian to no avail.

The family indicated they had no further service needs. In addition to paying for funeral costs, TCDSS provided the family with information on local food pantries and assisted with communication between the parents and DSS for public assistance.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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
Comments: The fatality has not yet been reviewed by the Child Fatality Review Team, but a review is scheduled.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051034 - Deceased Child, Male, 16 Days	051037 - Grandparent, Female, 58 Year(s)	DOA / Fatality	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051036 - Father, Male, 32 Year(s)	DOA / Fatality	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051039 - Aunt/Uncle, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051036 - Father, Male, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051035 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051039 - Aunt/Uncle, Male, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051035 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051040 - Unrelated Home Member, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051037 - Grandparent, Female, 58 Year(s)	Inadequate Guardianship	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051040 - Unrelated Home Member, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051038 - Grandparent, Female, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
051034 - Deceased Child, Male, 16 Days	051038 - Grandparent, Female, 50 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

Additional information:

Despite diligent efforts to locate, observe and assess the SS, TCDSS was unable to do so. TCDSS did not conduct comprehensive interviews of 3 subjects but did obtain written statements of LE's interviews of them.

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 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?	☐	☒	☐	☐

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	Not Offered	Needed but Unavailable	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:
TCDSS paid for the infant's funeral expenses. The family was asked if there was anything they thought TCDSS could

assist them with; specific services related to the fatality (aside from funeral expenses) were not noted in the documented discussions.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	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?	Yes
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

The father, paternal grandmother, and maternal grandmother had CPS history as alleged subjects in New York State more than three years prior to the fatality. There was no history on record for the maternal uncle's girlfriend. The mother and maternal uncle had no CPS history in New York State as adults.

6/6/15-7/27/15: Investigation was unfounded. Allegations of IG and IF/C/S were unsubstantiated against the father and paternal grandmother regarding the father's nephews, ages 1 and 2.

3/10/14-5/8/14: FAR case that came in with concerns against the father and paternal grandmother (amongst other adults) for an unkempt home and smoking in the presence of the father's asthmatic nephew. No safety concerns were revealed.

7/20/03-9/12/03: Investigation was indicated against the maternal grandmother for IG regarding the mother and maternal uncle as children.

10/14/02 and 10/19/02-12/23/02: Two investigations were indicated against the maternal grandmother for IG and LS regarding the mother as a child. She was also alleged of IG concerning the maternal uncle as a child, but that was unsubstantiated. The two separate reports concerned the same incident.

6/6/02-8/8/02: Investigation was indicated against the paternal grandmother for EdN concerning a paternal uncle as a child. She was also alleged of IG concerning that child, but that allegation was unsubstantiated.

Known CPS History Outside of NYS

Though formal documentation was not received as requested by TCDSS, they were informed through verbal communication with Bradford County Pennsylvania Children and Youth Services (CYS) that several adults had CPS history there. As noted in the case progress notes, TCDSS learned the following:

In 2011, the MGM was indicated as a “perpetrator by omission for deviant sexual intercourse, incest and sexual assault” and the MU was indicated for "statutory rape, incest and sexual assault by commission." It was noted the mother was removed from the MGM in 2011 as a result and was in foster care for four years. The agency reported there was CPS history with the father and PGM although their type of involvement, roles, and outcomes were not noted. Regarding the sibling, CYS reported services were put in place for the mother and MGM upon his birth. A case was opened on the mother and the sibling’s father in 2017 for being “inappropriate caregivers.” It was noted the sibling remained living with the mother and grandmother for a period, but there were concerns with the mother’s interaction with the child. CYS reported the sibling was currently in the care and custody of his paternal aunt, with visitation set up with the mother, though not frequent. It was unable to be confirmed whether the sibling’s custody arrangement was a family agreement or as a result of neglect.

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