Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-19-043

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

Issue Date: Feb 05, 2020

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Broome
Gender: Female
Date of Death: 08/27/2019
Initial Date OCFS Notified: 08/27/2019

Presenting Information

An SCR report alleged on 8/27/19, the 5-month-old child was found deceased in her Pack 'N Play at approximately 1:00 PM. The mother, grandmother and great-grandmother were in the home at the time the child was discovered. The mother put the child down to sleep after feeding her at 9:00 AM. The mother checked on the child at 11:30 AM, and at 1:00 PM when the child was found unresponsive. The mother called 911 while the great-grandmother performed CPR. When EMS arrived, the child was in rigor mortis and there was mottling where the blood had pooled into the skin. The child was in the Pack 'N Play with multiple blankets and a pillow.

Executive Summary

This report concerns the death of the 5-month-old female infant. Broome County Department of Social Services (BCDSS) received an SCR report and investigated the circumstances regarding the infant's death. The infant had no known pre-existing medical conditions and died suddenly while sleeping in an unsafe environment. BCDSS learned the infant resided in the home with her mother, maternal grandfather (MGF), maternal grandmother (MGM) and maternal great-grandmother (MGGM). There were no other children residing in the home and the infant had no siblings.

On 8/27/19, the mother woke with the infant and fed her. The mother placed the infant back into the portable crib in the mother's room when the infant was done eating and the mother also laid back down. The mother woke a few hours later and found the infant cold and unresponsive. The mother and grandmother were alerted and 911 was called. CPR was performed on the infant by the MGGM until EMS arrived and took over resuscitation efforts. The efforts to revive the infant were futile and her death was pronounced at the home.

An autopsy was performed and the ME reported the cause of death to be asphyxia due to an unsafe sleep environment. Further, the ME noted the lividity pattern on the face showed pallor over the mouth and nose, consistent with overlay.

LE jointly investigated the fatality with BCDSS and per the documentation in the CPS case record from September of 2019, it appeared the criminal investigation remained open at the time of this writing.

BCDSS interviewed all household members, the father and several collateral contacts during their investigation. BCDSS also requested and reviewed medical and law enforcement records. At the time of this writing a determination of the allegations had not yet been made and the CPS investigation remained open.

During the course of the investigation BCDSS offered counseling, burial assistance and referrals for bereavement services to the mother, father and all grandparents. There were no ongoing oversight services needed from BCDSS as there were no siblings or surviving children in the home.

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?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The CPS Investigation remained open at the time of this writing.

Was the decision to close the case appropriate? N/A

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 CPS Investigation remained open at the time of this writing.

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: 08/27/2019 **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: 01:03 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
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? 2 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	Deceased Child	Alleged Victim	Female	5 Month(s)
Deceased Child's Household	Grandparent	No Role	Male	50 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Other Adult - Great Grandmother	Alleged Perpetrator	Female	68 Year(s)
Other Household 1	Father	No Role	Male	21 Year(s)

LDSS Response

After receiving the report on 8/27/19, BCDSS coordinated their investigative efforts with LE and notified the DA of the fatality. A CPS history search was completed for the family and a home visit was promptly made to gather information.

The mother stated the evening of 8/26/19 was uneventful and after the infant was fed, she placed her to sleep in her portable crib at about 8:00PM. There was an adult size wearable blanket wrapped snuggly around the infant in the crib. The mother reported the blanket came up to the infant's chin. The mother went to sleep around 11:00PM that evening and woke again on 8/27/19 at 4:00AM when the infant woke to feed. The mother fed her and placed her back in the portable crib at about 6:00AM. The mother stated the infant went to sleep and at 9:00AM the mother checked on her. At 11:30AM the infant woke again and the mother fed her a bottle and then placed her back to sleep in the crib and also went back to sleep. The mother woke again at 12:30PM and checked on the infant a few minutes later and discovered she wasn't breathing. She then took the infant out of the crib, placed her on the bed and went downstairs to get help. She told the MGM something wasn't right with the infant and asked her to come upstairs. The MGGM overheard and ran into the bedroom and began CPR on the infant, while the mother called 911.

The mother had a history of drug use and admitted to using marijuana after the infants death. The mother tested positive for marijuana during the investigation, but denied any drug or alcohol use since the infant was born. The MGGM told LE that she was aware the mother used marijuana regularly, but was not sure if this occurred while she cared for the infant.

The MGM and MGGM reported the same events as the mother regarding the fatal incident.

The mother reported she had received safe sleep education and estimated she continued to co-sleep in the bed with the infant two days per week. The MGM and MGGM both stated they told the mother several times not to co-sleep with the

infant, warning her of the dangers.

The MGF stated he was at work when the infant was found unresponsive, but stated he was home for lunch at 11:50AM on 8/27/19 and checked on the infant. He stated she was in the portable crib, was breathing and had normal color. He also confirmed that the infant was wrapped in a blanket that was up to her chin, but not covering her mouth.

The father of the infant visited the home regularly, but was not at the home in the time leading up to the incident. The MGF called the father at work to inform him the infant died. The father reported last seeing the infant in person on the Friday before the incident. He denied any concerns with the care the infant received from anyone living in the home.

LE reported there was a pillow inside and a blanket draped over the side of the portable crib where the infant was sleeping. The mother told LE she placed the infant on her back and also found her this way. The infant reportedly had blood pooling on her face and LE suspected her face was pushed up against something while in the crib. In the last contact BCDSS documented with LE, LE was planning to present their investigation to the DA and agreed to let BCDSS know of any criminal charges.

BCDSS spoke with the first responders and the pediatrician during the investigation. First responders told BCDSS that the infant had obvious signs of death when they arrived at the home. EMS did try chest compressions and also a cardiac monitor, to no avail. The pediatrician reported no concerns in the care the infant was receiving and stated she was up to date with her appointments and vaccinations.

The CPS investigation remained open at the time of this writing and no determination had been made regarding the allegations.

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)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The death was referred to the Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051462 - Deceased Child, Female, 5 Mons	051464 - Grandparent, Female, 49 Year(s)	Inadequate Guardianship	Pending
051462 - Deceased Child, Female, 5 Mons	051466 - Other Adult - Great Grandmother, Female, 68 Year(s)	DOA / Fatality	Pending
051462 - Deceased Child, Female, 5 Mons	051466 - Other Adult - Great Grandmother, Female, 68 Year(s)	Inadequate Guardianship	Pending
051462 - Deceased Child, Female, 5 Mons	051463 - Mother, Female, 25 Year(s)	DOA / Fatality	Pending

051462 - Deceased Child, Female, 5 Mons	051463 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Pending
051462 - Deceased Child, Female, 5 Mons	051464 - Grandparent, Female, 49 Year(s)	DOA / Fatality	Pending

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The mother tested positive for illicit drugs during the investigation and admitted to drug use. The mother admittedly had a significant history of drug use for which she had received inpatient treatment in the past. There was no referral for a substance abuse evaluation noted in the case documentation, yet it may have been beneficial to the mother.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was provided with a bereavement packet which contained information on sources of support when processing grief. The family was also offered assistance with the funeral planning and payment.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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
☐ Had heavy alcohol use
☒ Smoked tobacco

☐ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☒ 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)	Allegation Outcome	Compliance Issue(s)
03/20/2019	Deceased Child, Female, 0 Days	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes

Report Summary:
An SCR report alleged on 3/20/19, the mother gave birth to the subject child. The mother tested positive for marijuana at the time of delivery. The roles of the father and the grandmother were unknown.

Report Determination: Indicated
Date of Determination: 05/29/2019

Basis for Determination:
The allegations were substantiated as the mother and child tested positive for marijuana and opiates at the time of delivery. The child's meconium also tested positive for morphine. The mother stated she had taken a pain pill for a tooth ache and that was causing the positive test. BCDSS was informed by medical personnel that a positive morphine test was indicative of heroin use and denied that the pill the mother reported taking would show positive for that substance. The mother tested negative for all substances at the conclusion of the investigation and agreed to a safety plan where she was supervised while with the infant.

OCFS Review Results:
The investigation was initiated timely. Safe sleeping recommendations and guidelines were provided to the parents. All family members were seen face-to-face and a safety plan was developed, and appropriate collateral contacts were made. The allegation determination was appropriate, however the investigation was closed with a safety plan actively in place. It was not appropriate to conclude the case with a plan to protect the child in place, as BCDSS would not be monitoring the plan. Ongoing preventive services were not offered to the family and this would have been appropriate given the risk elements identified during the investigation.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
Safety factor number 15 was not selected despite the infant's positive toxicology at birth. Additionally, the assessment was not completed and approved within the required timeframe.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances with regard to safety. Each Safety Assessment must be completed and approved within the required timeframes.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:

Multiple progress notes were entered six weeks after their event dates.

Legal Reference:

18 NYCRR 428.5

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:

Failure to offer services

Summary:

The case was closed with a safety plan still in place and a high risk rating, indicating the need for intervention. There was no documentation in the case record that services were offered to the family prior to case closure to mitigate the documented risk.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, BCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The Risk Assessment Profile did not include a secondary caretaker, although other adults resided in the home, and the father was actively involved in the life of the infant.

Legal Reference:

18 NYCRR 432.2(d)

Action:

BCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

[redacted]

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

The family was involved in two CPS investigations from 12/10/01 to 5/17/10. The reports were unsubstantiated against the grandmother and great grandmother for IG and SA of another child. Another report was substantiated for IG and L/B/W against another adult regarding a child.

Known CPS History Outside of NYS

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

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

Additional Local District Comments

BCDSS agrees with OCFS' findings concerning BCDSS' fatality investigation. That BCDSS interviewed all appropriate collateral contacts, the death scene investigation was properly performed, BCDSS coordinated their investigation with law enforcement, and BCDSS' investigation documentation was all completed in a timely manner.

Concerning this report's historical finding about a prior investigation, BCDSS did obtain a Safety Contract with the mother and adult household family members. Among other things, BCDSS' Safety Contract and Plan of Safe Care prohibited the mother from drug use. The mother moved in with family members who agreed to provide a clean, stable, safe home with family supervision and appropriate supports for the child. The mother established WIC eligibility and scheduled the child for a pediatric appointment. At the closing of that prior case, with above plan in place, the mother screened negative for drug use.

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