Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-016

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

Issue Date: Sep 30, 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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Broome
Gender: Female
Date of Death: 04/13/2020
Initial Date OCFS Notified: 04/13/2020

Presenting Information

Broome County Department of Social Services (BCDSS) received a report from the SCR alleging, on 4/10/20, the mother woke around 3:30AM to breast feed the 6-month-old subject child and placed her back in her crib. At 10:15AM the mother entered the subject child's bedroom to find the father in the room and the subject child lying in the crib, unresponsive. There were various articles of clothing and a car seat in the crib. It was unknown if the child was fastened in the car seat. The mother contacted the Emergency Response Team and then began to perform CPR on the child. EMS arrived and transported the subject child to the hospital for medical attention. Shortly after arrival, the child was transported to another hospital for further medical attention. Once there, the child was intubated and examined. No signs of external or internal injuries were present. On 4/12/20 and 4/13/20, brain death tests were performed, and the child failed both tests and was determined to be brain dead.

Executive Summary

Broome County Department of Social Services (BCDSS) received a report from the SCR on 4/13/20, concerning the death of the 6-month-old child. The child became unresponsive in her crib while at home with the parents. An initial report was registered with the SCR on 4/10/20 when the child was found unresponsive at home. A fatality report was registered with the SCR on 4/13/20 when the child was taken off life support and pronounced brain dead at 12:00PM.

The subject child resided at home with the mother and father. There were no surviving siblings or other children residing in the home. BCDSS completed a joint investigation with law enforcement and no criminal charges were filed. An autopsy was completed and revealed the cause of death was Sudden Death of an Infant and the manner of death was undetermined.

During the investigation, it was learned the mother and father were both at home with the subject child on the evening of 4/9/20. The night leading up to the death was typical and the subject child ate and napped normally. The mother stated the father placed the subject child to sleep around 10PM on the night of 4/9/20 after the mother fed and changed her. The mother was alerted around 3:30AM when the child began crying. The mother found the subject child strapped into her car seat at that time, which was something that the parents frequently did. The mother reported she believed the child was safest sleeping strapped into her car seat. At 3:30AM, the mother fed and changed the child before the father put her to sleep. The record reflects the mother was initially unsure of whether the child was placed to sleep in the bassinet or back in her car seat as the father placed the child to sleep. When interviewed later, both parents reported the child was placed to sleep, on her back in her bassinet. When the mother woke around 10AM, she found the father standing over the bassinet. The father reported the child was not breathing and the mother immediately began resuscitation efforts while the father called 911. First responders arrived and transported the child to the hospital where she remained on life support until ultimately succumbing to her injuries on 4/13/20.

As part of their response, BCDSS interviewed all first responders who were present on the day of the incident. BCDSS contacted all necessary collaterals and determined there was credible evidence to substantiate the allegations of inadequate guardianship, lack of supervision, and DOA/fatality against the father regarding the subject child. The family was agreeable to referrals for community-based services and began the process of participating in mental health and bereavement counseling. Once all casework activities were completed adequately, the case was closed. BCDSS conducted a thorough investigation in accordance with multidisciplinary standards and recorded casework activity and required assessments timely and accurately. At the time of this writing, the investigation remained open.

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:
Casework activity was commensurate with case circumstances. The 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:
Casework activity was commensurate with best casework practice as outlined in the CPS manual. At the time of this writing, the investigation remained open.

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: 04/13/2020 **Time of Death:** 12:00 PM

Date of fatal incident, if different than date of death:	04/10/2020
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: 09:50 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:

- [x] 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? 7 Hours
At time of incident supervisor was:

- [ ] Drug Impaired
- [ ] Alcohol Impaired
- [ ] Distracted
- [ ] Impaired by disability
- [ ] Absent
- [x] 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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

BCDSS promptly initiated their investigation upon receipt of the SCR report concerning the fatality. Within 24 hours, ECDSS collaborated amongst their staff and law enforcement, notified the District Attorney and medical examiner, checked for CPS history, conducted home visits, and interviewed the family members.

Through interviews conducted with family members and first responders, it was learned the day leading up to the death was typical. Both parents were home caring for the child and the child ate and napped normally. It was common practice for the mother to feed and change the child and then the father would place the child down for a nap. On 4/9/20, the mother fed and changed the child at approximately 10PM. The father then placed the child to sleep. It was learned she was strapped into her car seat, which was then positioned in the bassinet. The mother woke and fed the child again around 3:30AM. The father then placed the child to sleep in the bassinet. The father reported he placed the infant down on her back in the bassinet at that time. The parents alleged the car seat was placed outside of the bassinet. It was learned the parents chronically placed the child to sleep strapped into her car seat, despite being educated by BCDSS on several occasions leading up to the death. Around 10AM on the morning of 4/10/20, the mother woke and entered the subject child’s room, where she found the father standing over the bassinet staring inside. When questioned, the father told the mother the child was not breathing. The mother immediately began CPR while the father called 911 after being prompted to do so by the mother. EMS arrived and transported the child to the hospital.

Hospital records regarding the subject child were received. Records reflected the child presented to the ER in cardiac arrest. The PICU team provided continuous resuscitation upon her arrival at the ED. Palliative care continued until 4/13/20 when the child succumbed to her injuries.

The infant's regular place of sleep at the family's own home was strapped into her car seat, though BCDSS observed they had a crib. The mother reported she believed the child was safest strapped into her car seat to sleep. The parents confirmed they were advised of infant sleep safety prior to the fatality. BCDSS discussed safe sleep with the family in detail and provided an array of written materials regarding child safety and prevention.

Due to concerns for Covid-19, BCDSS questioned the family's recent medical history. The family denied that either the infant or anyone else in the home was recently ill. Medical records reflected the infant had been last seen by her pediatrician in February and there were no notable concerns.

At the time of this writing, the investigation remained open pending case closure.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical 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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054961 - Deceased Child, Female, 6 Mons	054962 - Mother, Female, 23 Year(s)	DOA / Fatality	Pending
054961 - Deceased Child, Female, 6 Mons	054962 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Pending
054961 - Deceased Child, Female, 6 Mons	054963 - Father, Male, 24 Year(s)	DOA / Fatality	Pending
054961 - Deceased Child, Female, 6 Mons	054963 - Father, Male, 24 Year(s)	Inadequate Guardianship	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:
BCDSS provided the parents with a multitude of resources. At the time of this writing, the parents were engaged in mental health services.

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? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BCDSS offered a number of services to the parents. Parents were receptive to services and engaged at the time of this writing.

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? 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)	Allegation Outcome	Compliance Issue(s)
12/26/2019	Deceased Child, Female, 3 Months	Mother, Female, 22 Years	Lack of Supervision	Unsubstantiated	Yes
	Deceased Child, Female, 3 Months	Father, Male, 24 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
BCDSS received a report from the SCR on 12/26/19 alleging the parents left the infant at home alone for extended periods of time. Specifically, on 12/26/19 the father left the infant home alone for approximately a half hour.

Report Determination: Unfounded **Date of Determination:** 02/07/2020

Basis for Determination:
BCDSS determined there was not sufficient evidence to support the allegations. BCDSS assessed the infant to be safe in the care of the parents. The parents and collateral sources denied the infant had been left home alone.

OCFS Review Results:
BCDSS did not interview and address allegations and ongoing concerns with the mother, who was also a subject of the report. BCDSS did not enter progress notes contemporaneously to their event dates. Though BCDSS did not complete the 7-day safety assessment tool, BCDSS assessed the safety of the child and documented safety in the case record.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
BCDSS entered many of the progress notes more than a month after their event dates.

Legal Reference:
18 NYCRR 428.5

Action:
BCDSS will enter all progress notes as contemporaneously to their event dates as possible.

[redacted]

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

There was no known history outside of New York.

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' finding, "BCDSS conducted a thorough investigation in accordance with multidisciplinary standards and recorded casework activity and required assessments timely and accurately."

Concerning contemporaneous entry of notes into OCFS' system, BCDSS administration will remind staff of the importance of contemporaneously entering notes into OCFS' mandated system.

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