NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-16-004 **Prepared by: Rochester Regional Office**

Issue Date: 8/26/2016

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	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		

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Ontario
Gender: Male
Date of Death: 02/23/2016
Initial Date OCFS Notified: 02/24/2016

Presenting Information

On 2/23/16, the SC was in the care of his BM and BF. At approximately 12 noon BF woke up with SC in his arms and found the SC was blue in color and unresponsive. BM and BF called 911. The SC was later pronounced dead. The SC had no known preexisting health conditions and there is no explanation that has been provided for his death.

Executive Summary

This report concerns the death of a 3 month old male infant SC that occurred on 2/23/16 in Ontario County. The investigation was transferred to Monroe County due to the employment of the maternal grandmother with Ontario Co. DSS. On 2/23/16 at approximately 10:30am, SC was fed by the BF and the child fell asleep on his chest on the living room couch. BF states that he fell asleep and when he woke he found the SC not breathing. BM immediately called 911. SC was transported to the hospital via ambulance at 12:52pm. SC was pronounced deceased at 1:50 pm at the hospital.

Law Enforcement arrived at the residence and noted the presence of items in the household commonly used to ingest illegal substances. LE secured a warrant to search the residence and at the time of this report a criminal investigation is pending against the BF.

According to the preliminary information received from the ME's office the cause of death is unknown and the autopsy results are pending.

On 2/24/16 the SCR and MCDHS, on behalf of Ontario County initiated an investigation for allegations of Inadequate Guardianship and DOA Fatality against the SM and BF regarding the SC. A safety assessment revealed no other children in the home. Monroe County Department of Human Services (MCDHS) and LE met with the parents in the home on 3/2/16. Bereavement services were offered. SM did admit to a history of substance use and the continued use of Suboxone to prevent her return to Heroin use. BF also has a history of substance use. SC was born with neonatal abstinence syndrome requiring a 14 day stay in the neonatal ICU for treatment.

MCDHS made appropriate collateral contacts to obtain information about the SC's health, care, and subsequent death.

At the time of this report the investigation remains open. The criminal investigation is currently active and no arrests have been made.

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:
see executive summary

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:
see executive summary

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: 02/23/2016 **Time of Death:** 01:50 PM

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

County where fatality incident occurred: ONTARIO
Was 911 or local emergency number called? Yes
Time of Call: 12:30 PM
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: Not impaired.

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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	55 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)

LDSS Response

On 2/24/16 the SCR received a report of a child fatality naming the SC mother and biological father of Inadequate Guardianship and DOA/Fatality. The SC was pronounced dead at 1:50pm.

The death occurred in Ontario County but the investigation was transferred to Monroe County as the MGM works for Ontario County DSS and resides in the same home as the alleged subjects. 2/24/16 the BF reported that he woke and fed the SC at approximately 10:00am. He sat on the couch with the SC on his chest. BF reports fell asleep and when he woke up he looked down at the SC and noted that he was not breathing. BF called for SM, who was asleep in the bedroom, she called 911. SC was last seen alive at 10:30am.

BF and SM gave consistent accounts of events when interviewed by LE. 2/25/16 a safety assessment was completed and there are no surviving sibling in the home. The SC frequently slept in a rock-an-play. The SC was born with positive for Suboxone and spent two weeks in the NICU to be weaned from the drug. SC was considered a healthy 3 month old. MCDHS and LE conducted a joint investigation. Collateral contacts with the attending hospital, pediatrician and hospital of birth were made.

The SC was transfered to the Monroe County Medical Examiner on 2/24/16, with an autopsy performed on 2/25/16. There were no signs of any physical injuries or trauma. The home was searched by LE with drug items found in the home. No arrests have been made at this writing.

Collateral contact with the primary care physician indicate that the SM and BF were provided with safe sleep information.

SM tested positive for Suboxone and Cocaine and Amphetamines and is currently in mental health treatment. BF tested positive for Marijuana, Amphetamines and Suboxone. BF has been non compliant with recommended treatment. MCDHS offered the family appropriate services.

The case remains open and there are no surviving children in the home. Autopsy results are pending at the time of this report.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Hospital physician

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
030121 - Deceased Child, Male, 3 Mons	030123 - Father, Male, 37 Year(s)	Inadequate Guardianship	Pending
030121 - Deceased Child, Male, 3 Mons	030122 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Pending
030121 - Deceased Child, Male, 3 Mons	030122 - Mother, Female, 31 Year(s)	DOA / Fatality	Pending
030121 - Deceased Child, Male, 3 Mons	030123 - Father, Male, 37 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	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

There is no CPS investigative history within three years prior to the fatality.

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.

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