NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SY-15-020 **Prepared by: Syracuse Regional Office**

Issue Date: 2/22/2016

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: 15 day(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 05/06/2015
Initial Date OCFS Notified: 05/07/2015

Presenting Information

On 5/7/15, the SCR registered a report noting the following: last night (5/6/15) the 18-day-old SC was in full cardiac arrest while in the BM's and BF's care. The SC had blood coming out of her mouth and has since passed away. There are no known medical issues with the SC, making the death suspicious. The allegations of IG and DOA/Fatality were registered against the BM and BF. No other children were listed as living in the home.

Executive Summary

The fatality report concerns the death of a 15-day-old child. The SC was pronounced dead on 5/6/15 at 9:30pm. The autopsy listed the manner of death as undetermined. The cause of death was listed as, "Sudden unexplained infant death (SUID) while bed sharing with adult."

The LDSS investigation revealed that the BM and the SC were co-sleeping on the same full-sized adult bed. The BM placed the SC on her back, on a soft pillow that was covered with a receiving blanket. She then tucked a second receiving blanket around the SC with the SC's arms outside of the blanket. The SC had a pacifier in her mouth and was facing left when the SC fell asleep. The BM fell asleep shortly thereafter, and awoke approximately six hours later to find the SC in the same position, but with the pacifier out of her mouth. The SC was not breathing. There was blood on, the SC's mouth and nose, as well as the blanket. EMS was called and the SC arrived at the hospital in cardiac arrest. The SC passed away at the hospital.

On 6/10/15, the LDSS completed their investigation and unsubstantiated the allegations of IG and DOA/Fatality against the BM and BF. The LDSS appropriately determined the allegations in the report. There were no surviving children in the home; therefore ongoing services were not required.

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:

The LDSS' investigation lacked information, but this did not affect the determination, or closing, of the report.

Was the decision to close the case appropriate?	Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
The decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The LDSS failed to obtain and document necessary information related to the parents' knowledge of safe sleep, the condition of the Pack and Play, as well as why the SC's medical appointments were missed.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2
Action:	The LDSS will submit a corrective action plan within 45 days that identifies what action has been taken, or will be taken, to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/06/2015 **Time of Death:** 09:30 PM

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

County where fatality incident occurred:	ONONDAGA
Was 911 or local emergency number called?	Yes
Time of Call:	08:56 PM
Did EMS to respond to the scene?	Yes
At time of incident leading to death, had child used alcohol or drugs?	N/A

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? 6 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Female	15 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Other Household 1	Sibling	No Role	Female	20 Year(s)

LDSS Response

The LDSS investigation revealed that on 5/6/15, the SC awoke at 7:30am. The SC had slept in her Pack and Play the night before. The BM changed the SC's diaper, fed her 2 oz. of formula, and placed the SC back in the Pack and Play to go to sleep. The SC awoke at 10:00am. The BM changed the SC's diaper, fed her 2 oz. of formula, and placed the SC back in the Pack and Play to go to sleep. The LDSS' documentation did not reflect the condition of the Pack and Play, the contents of the Pack and Play, how the SC was placed in the Pack and Play (supine, prone, etc.), or what knowledge the BM and BF had regarding safe sleep practice.

The SC awoke between 1:00-1:30pm. The BM changed the SC's diaper and fed her 1 ¾ oz. of formula. The BM laid the SC next to her on a full-sized bed. The BM placed a receiving blanket on top of an adult-sized soft pillow that was next to the BM. The BM placed the SC on her back; on the pillow. The SC's upper torso was on the pillow and her lower torso was on the bed. The BM wrapped the SC in a second receiving blanket that was tucked under the SC. The SC's arms were outside of the blanket. It was a warm day, but there was an air conditioner on in the room. The SC was facing left and the BM put a pacifier in the SC's mouth. The pacifier came out of the SC's mouth twice, and the BM put it back in the SC's mouth both times.

The BM last saw the SC asleep at approximately 3:00pm. The BM was tired and fell asleep shortly thereafter. Approximately 6 hours later, at 9:00pm, the BM awoke to find the SC in the same position as the BM placed her in, but with the pacifier out of her mouth. The SC was not breathing and there was blood on, the SC's mouth and nose, and blanket. The BF had been in and out of the home all day. He was in the bathroom of the home when he heard the BM say the SC wasn't breathing. The BF called 911. The BM gave the SC CPR until EMS arrived and immediately transported the SC to the hospital. The SC was in cardiac arrest upon arrival and was unable to be revived. The SC was pronounced dead at 9:30pm.

An autopsy was performed and the manner of death was listed as undetermined. The cause of death was listed as, "Sudden unexplained infant death (SUID) while bed sharing with adult." There were no injuries noted to the SC. The BM received

prenatal care and no risk factors were noted with her pregnancy. The SC's delivery was very quick, which resulted in the SC having fluid in her lungs. The SC was in the NICU for 5 days and released in good health. The SC was not ill at the time of death. There was no noted anatomic cause of death. The SC was seen for a well-child check on 4/28/15 and the SC's weight was down by 5%. Follow up appointments on 5/1/15 and 5/6/15 were missed. The LDSS' documentation doesn't reflect why the appointments were missed. The Syracuse Police Department investigated the SC's death and found nothing suspicious regarding the circumstances surrounding the SC's death. Grief counseling services were offered to the SC's parents, but were refused.

On 6/10/15, the LDSS completed their investigation and unsubstantiated the allegations of IG and DOA/Fatality against the BM and BF. The LDSS appropriately determined the allegations in the report as there was not enough credible evidence to establish causation between co-sleeping, the unsafe sleep furniture, and the SC's death. There were no surviving children in the home; therefore ongoing services were not required. As noted in this narrative, the LDSS lacked information in their report, however the lack of information, did not impact the determination of the investigation.

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
024341 - Deceased Child, Female, 15 Days	024342 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
024341 - Deceased Child, Female, 15 Days	024343 - Father, Male, 39 Year(s)	DOA / Fatality	Unsubstantiated
024341 - Deceased Child, Female, 15 Days	024342 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
024341 - Deceased Child, Female, 15 Days	024343 - Father, Male, 39 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief counseling services were offered.

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? 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
☐ 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 fetal alcohol effects or syndrome

☒ With neither of the issues listed noted in case record

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

The SC's paternal half-sibling was listed in 9 CPS reports as an alleged maltreated or abused child between 2001-2010. The reports were investigated by the Onondaga County Department of Social Services. The SC's half-sibling never resided with the SC. Of the 9 reports, the half-sibling was confirmed to be maltreated in 7 reports, and confirmed to abused in 1 report. For the purposes of this narrative, the half-sibling will be referred to as the other child (OC).

In November 2001, an initial report was registered with the SCR. A subsequent report followed in March 2002, and two more subsequent reports followed in May 2002. All four reports were determined in July 2002. The OC's BM was IND for IG, LABW, IFCS, and PDAM. The OC's BM's home was unclean and unsafe, drugs and drug paraphernalia were accessible to the OC, and the OC was hit by a belt leaving welts. A neglect petition was filed on behalf of the OC, and ongoing protective services were provided from April 2002 to May of 2006, when the OC's MGF was awarded custody of the OC. However, after the services were closed the OC's MGF allowed the OC to return to the OC's BM's home.

In January 2005, the OC's MGF was IND for XCP, IG, and LBW for hitting the OC with a belt leaving bruises. In June 2009, the BM's paramour was IND for SA for raping the OC. In September 2010, the OC was confirmed to be maltreated by the OC's BM. The OC's BM was IND for IG for allowing the OC to reside in an unclean and unsafe home.

Known CPS History Outside of NYS

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

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

Ongoing protective and preventive services were provided to the OC and the OC's BM beginning on 4/13/02. The services were provided as a result of IND CPS reports. The BM lacked parenting skills to maintain a clean and safe home and to provide non-excessive discipline to the OC. The BM had a drug addiction and allowed drugs, drug paraphernalia, and drug deals in the presence of the SC. During the course of service provision, the BM did not make sufficient progress to

increase her skills in order to reduce risk to the children, and to close the services case. The MGF applied for custody of the OC and was granted permanent physical and legal custody of the OC on 3/22/06. The ongoing services case was closed on 5/24/06 as the OC was no longer at risk of placement, and had obtained permanency due to the custody transfer.

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