Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-043

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

Issue Date: Feb 25, 2021

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: 7 month(s)
Jurisdiction: Broome
Gender: Female
Date of Death: 09/26/2020
Initial Date OCFS Notified: 09/26/2020

Presenting Information

Broome County Department of Social Services (BCDSS) received an SCR report that stated on 9/26/20 at approximately 4:45AM, the mother went to feed the 7-month-old subject child and found her not breathing. Further details were unknown. It was unknown where the child was sleeping. The child was pronounced deceased at 6:20AM. The mother had no explanation for the death.

Executive Summary

On 9/26/20, BCDSS received the SCR report regarding the death of the 7-month-old subject child that occurred on the same day. Prior to the fatality, the SC resided with the mother and father. At the time of the death, the child was home with the mother, a family friend, 3-year-old cousin and the cousin's mother, who were visiting for the night. The father was away for work. There were no surviving siblings or other children who resided in the household.

BCDSS learned through casework and collateral contacts that the day leading up to the fatality, the mother picked up the subject child from the maternal grandmother's home. The grandmother had been babysitting the child while the parents were at work. The mother and child returned to the home and spent the evening with their family who were visiting for the night. The mother and adult guests reported they had been consuming alcohol throughout the evening, but denied anyone had drank to the point of intoxication. The mother fed and bathed the subject child around 10:30PM and at an unknown time they went to sleep. The mother put the child to sleep in a basinet in the same room as her. The mother stated she always followed safe sleep guidelines and all relatives interviewed denied the mother ever co-slept with the child. The mother woke around 4:45AM and checked on the subject child and found her unresponsive in the basinet. The mother, family friend and cousin's mother called 911 and performed CPR. First responders arrived and transported the child via ambulance to the hospital where she was pronounced deceased after unsuccessful life saving measures.

An autopsy was completed and revealed that the subject child's cause of death was acute renal failure with no gross or microscopic renal abnormalities. The etiology of the renal failure was unknown; therefore, the manner was undetermined. The pathologist reported they were continuing to try to determine what caused the renal failure and inquired about medication the child might have had access to prior to her death. The mother denied being on medication and the grandmother stated she took medication for a prior medical diagnosis, but it was not accessible to the child. They both reported the child was not mobile and denied she would have been able to consume anything. It was determined through contact with the pediatrician and birth records that the child had no prior diagnosed medical concerns related to the fatality. LE found there to be no criminality related to the fatal incident and their criminal investigation was closed.

BCDSS documented several efforts to complete a home visit and interview the father. The father refused to participate in an interview and the attempted home visits were unsuccessful. BCDSS completed and submitted the 30-Day Fatality report on time, but it was not approved until three months later. The family was offered grief counseling and mental health services following the fatality. The allegations against the mother had not been determined and the CPS investigation remained open at the time this report was written.

PIP Requirement
BCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the BCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, BCDSS will review the plan and revise as needed to address ongoing concerns.

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 had not yet been determined at the time this report was written.

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:
There was supervisory consultation documented throughout the case record. Although several progress notes were entered non contemporaneously with their event dates, all required casework activity was completed. The investigation remained open at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Approximately 25 notes were entered more than a month after their event date.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/26/2020 **Time of Death:** 06:20 AM

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: 04:45 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? 3 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	7 Month(s)
Deceased Child's Household	Father	No Role	Male	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)

LDSS Response

On 9/26/20, BCDSS received an SCR report regarding the death of the SC that occurred on 9/26/20. Within 24 hours of receipt of the SCR report BCDSS spoke to the source, completed a CPS history check, spoke to LE and notified the district attorney's office.

BCDSS interviewed the SM and she reported the SC was in the care of the MGM the day prior to her death while the SM and BF were at work. The MGM stated that the SC acted as she normally would and there were no medical issues while she cared for her. The MGM further stated that she had no concern for the parents' care of the SC and that they took excellent care of her. The SM picked the SC up from the MGM and brought her home around 5:00PM. The SM had family visiting and she reported they were drinking, but did not provide additional information on this. At approximately 10:00PM, the SM gave the SC a bottle, bathed her, then gave her the remainder of her bottle. The SM did not recall what

time she and the SC went to sleep but stated she placed the child to sleep in her basinet, which was in the SM's bedroom. The SM reported she always put the SC to sleep on her back; however, the child would roll onto her stomach and wiggle her face into the side of the basinet. The SM denied co-sleeping, denied there were any items in the basinet and stated that she always followed safe sleep guidelines. The SM typically would wake up throughout the night to check on the SC because she knew the child liked to sleep with her face against the basinet. The SM woke up around 4:45AM and checked on the SC. The SC had rolled onto her stomach and the SM put her hand on the SC's back and felt she was not breathing. The SC felt warm and limp. The SM picked the SC up and ran her out to the living room where her guests were sleeping. The SM's friend attempted to scoop out anything that may have been in her mouth and some liquid came out. The SM's friend and SM called 911 and the 3yo cousin's mother performed CPR until first responders arrived and transported the SC to the hospital.

The SC was transported to the hospital by EMS and given several rounds of epinephrine and intubated. Upon arrival to the hospital the SC had a temperature of 92.3 degrees. Medical staff attempted life saving measures for over an hour; however, the child was not breathing and had no heartbeat and was pronounced deceased at 6:20AM.

The family friend and cousin's mother were interviewed and confirmed they were present at the time of the death. BCDSS questioned them about alcohol consumption and they stated they had been drinking beer and vodka, but denied anyone was impaired or that there had been any drug use. The family friend and cousin's mother reported they woke to the SM screaming and bringing the SC into the living room. They assisted the SM in calling 911 and performing CPR. They denied the SC had been acting abnormal or that they had any concerns for the care of the SC. There were several family members at the hospital following the fatality, all of whom denied the mother co-slept with the SC. BCDSS assessed the safety of the 3-year-old cousin while at the hospital.

BCDSS documented efforts to conduct a face-to-face interview with the BF; however, he refused to participate in the CPS investigation. BCDSS attempted to complete a home visit at the residence, but the family was not home during unannounced visits. The SM was staying with the MGM for support following the fatality. LE reported that they had no concerns with the condition of the SC's home.

BCDSS gathered information regarding the SC's medical care and it was learned that the child was born two months premature and was in the intensive care unit for 2 weeks following her birth. The SC's lungs were not fully developed but she had no other medical issues. The SC was up to date on all routine medical appointments and immunizations, was healthy and without any illnesses.

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: Pathologist

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: BCDSS indicated in their 24-hour and 30-day fatality reports that the death would be reviewed by their Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056382 - Deceased Child, Female, 7 Mons	056384 - Mother, Female, 28 Year(s)	DOA / Fatality	Pending
056382 - Deceased Child, Female, 7 Mons	056384 - Mother, Female, 28 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?	☐	☒	☐	☐

Additional information:

BCDSS documented several efforts to interview the father face-to-face and complete a home visit. The father refused to be interviewed by Child Protective Services and attempted home visits were unsuccessful.

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	☐	☐	☐	☐	☐	☒	☐

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 residing 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 provided the parents with a bereavement packet, which contained information regarding grief services.

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? 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 in NYS within three years prior to the fatality.

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

In 2003, the father had one CPS investigation in Manhattan which was indicated for IG in relation to the father's younger siblings.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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