NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-15-014 **Prepared by: Buffalo Regional Office**

Issue Date: 3/25/2016

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: 1 month(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 04/07/2015
Initial Date OCFS Notified: 04/07/2015

Presenting Information

Today, April 7, 2015, at approximately 11:50AM, subject mother (SM) found one month old subject child (SC) unresponsive. Subject mother contacted emergency medical services and subject child was pronounced dead upon arrival. Subject child did not suffer from any medical conditions that would contribute to his passing. Subject child was an otherwise healthy child and there is no explanation for his death at this time.

Executive Summary

On 4/7/15, the CW initiated the investigation making contact with subject mother (SM), first responders, Police, and later following up with other collateral contacts including pediatric, medical providers, family members, and gathering some case history.

The first responders reported upon their arrival the subject child (SC) was non-responsive, was last reported as seen alive at 5AM, and rigor mortis had begun indicating SC had been deceased for hours. They also noted a deviated nose and markings on SC from blood pooling indicating SC has died face down.

The Hospital ER reported SC was DOA with no vitals. Medical providers reported no previous care concerns or illnesses.

SM reported she was baby-sitting her cousin's five year old, but left her sister to babysit while she went to buy beer returning at 2AM. She reported her cousin's son and SC were both sleeping. When she returned, her sister went home. SC woke at 5AM and fed SC, changed him, and played with him before putting him back in his bassinet at 6AM. SM reported laying SC on his side, because he was congested and covering SC with a blanket before going back to sleep herself. She reported her cousin's son woke at 7AM and she checked on SC at 8AM observing him face up and doing fine. SM reported she then did some laundry and cleaning and fed her cousin's son cereal at 9AM. SM stated she later saw her cousin's son playing near the bassinet and was surprised that SC was not startled prompting her to check again. She then found SC face down, yellow, and his legs were cold. She then took SC to Maternal Grandfather's (MGF) room yelling for help and gave SC to him, called 911, and ran downstairs to her sister's home. SM reported that she, her sister, and MGF all tried to perform CPR on SC until the ambulance arrived.

Police reported a medium sized stuffed animal and blanket were in the bassinet with SC. They reported SM had alcohol on her breath, a partial tall can of high alcohol beer was still cold, and that a number of empty cans of the same beer were also found. The MGF reported both he and SM had been drinking the previous night. The MGF reported SM came to his room with SC not breathing and he tried to put his oxygen tube into SC's mouth, but he couldn't open SC's jaw. The MGF also reported that SM had four children removed from her two years ago.

The Erie Co. Medical Examiner performed an autopsy and initial findings were accidental death by positional asphyxia. The final autopsy report was pending toxicology results and was not available at the time of this fatality review.

On 6/10/15, the allegations of DOA/Fatality and IG were indicated against SM. The basis of findings include the SM was consuming alcohol the night before and possibly during the time of SC's death. Police found a beer can which was still cold next to SC's bottle. All reports from Police and Hospital state SM had a strong odor of alcohol. The autopsy report states cause of death as positional asphyxiation. The SM admits to placing baby on his side in his bassinet due to congestion. The SM found SC several hours later face down and not breathing. The SM has no other children in her care/custody. The CW reported contacting Florida CPS, but did not obtain any case history records. It is unknown if the children were surrendered or parental rights were terminated. The report was closed before obtaining any history from Florida regarding SM'S other children.

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:
SM reported she has other children in Florida for which she does not have custody. It is unknown if these children were surrendered or if SM's parental rights were terminated. The circumstances events leading to SM not having custody of these children would be important to know. Records should be obtained from Florida as well as sharing of this fatality information regarding this fatality eve

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Review of CPS History
Summary:	There is no information on CPS history or history of removals in Florida. It is unknown if her other children were surrendered or terminated.There is no criminal background check on SM from Florida or NY. No explanation of incarceration history.

Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	When there is information that a family has prior CPS and criminal history in another State, the investigation case should not be determined or closed without first obtaining documentation of that out-of-state history which could provide crucial information regarding risk/ safety factors in the case.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The grandfather and renter (father of SM's sister who lives downstairs) that resided in the home were not added this case and there is no documentation of any background checks on either of them.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2
Action:	All household members should be added to an open case and CPS background and criminal record searches should be completed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There is no documentation of contact with SM's treatment counselor. Her use history, restrictions, and current use are important to know regarding risk and safety factors. Was substance abuse a factor In not having custody of her other children?
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	Obtaining treatment records should be required for any SCR report subject when substance use is part of the reported incident.
Issue:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	There is no documentation regarding SM's level of intoxication/ impairment. Grandfather and SM were not questioned regarding amount of alcohol each consumed that night which could have been matched to cans found.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	Details related to substance impairment of an SCR fatality report subject should be fully explored to determine contributing factors in relation to the death of the child.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/07/2015 **Time of Death:** Unknown

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

County where fatality incident occurred: NIAGARA
Was 911 or local emergency number called? Yes
Time of Call: 11:41 AM
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
How long before incident was the child last seen by caretaker? 160 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☒ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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	1 Month(s)
Deceased Child's Household	Grandparent	No Role	Male	63 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Other Adult	No Role	Male	20 Year(s)

LDSS Response

On 4/7/15, the CW initiated the investigation making contact with subject mother (SM), first responders, Police, and later following up with other collateral contacts including pediatric, medical providers, family members, and gathering some case history.

The first responders reported upon their arrival the subject child (SC) was in the arms of the maternal grandfather (MGF) and was non-responsive. Upon their inquiry they reported the MGF and SM reported last seeing SC alive at 5AM. As SC was taken to the ambulance, his right arm was noted as stiff and it appeared SC had been deceased for hours. They also noted a deviated nose and markings on SC from blood pooling. Buffalo Fire reported starting to ventilate and perform CPR, but then SC was taken by Rural Metro for transfer to the hospital.

The hospital ER reported SC was DOA with no pulse, heartbeat, or breathing and was in rigor mortis. Medical providers reported no previous care concerns or illnesses.

SM's sister, who lives downstairs, reported that she was in SM's apartment helping her with the baby, watching their father (MGF) who has COPD, and were up watching TV most of the night. She reported that SM was drinking beer, but

that she herself was not.

SM reported she was baby-sitting her cousin's five year old, but left her sister to babysit while she went to buy beer returning at 2AM. She reported her cousin's son and SC were both sleeping. When she returned, her sister went back to her apartment. SC woke at 5AM and SM fed him 5 ounces of formula, changed him, and played with him before putting him back in his bassinet at 6AM. SM reported laying SC on his side, because he was congested and covering SC with a blanket before going back to sleep herself. She reported her cousin's son woke at 7AM and she checked on SC at 8AM observing him face up and doing fine. SM reported she then did some laundry and cleaning and fed her cousin's son cereal at 9AM. She said she later saw her cousin's son playing near the bassinet and was surprised that SC was not startled prompting her to check again. She then found SC face down, yellow, and his legs were cold. She then took SC to her father 's room yelling for help and gave SC to him, called 911, and ran downstairs to her sister. SM reported that she, her sister, and MGF all tried to perform CPR on SC until the ambulance arrived.

Police reported a medium sized stuffed animal and blanket were in the bassinet with SC. They reported SM had alcohol on her breath. One ¼ full tall can of "Hurricane" high alcohol beer, still cold, was found. A number of empty cans of the same beer were also found in a barrel. The MGF reported both he and SM had been drinking the previous night. The MGF reported SM came to his room before noon with SC not breathing and he tried to put his oxygen tube into SC's mouth, but he couldn't open SC's jaw. The MGF also reported that SM had four children removed from her two years ago.

The Erie Co. Medical Examiner performed an autopsy and initial findings were accidental death by positional asphyxia. The final autopsy report was pending toxicology results and was not available at the time of this fatality review.

On 6/10/15, the allegations of DOA/Fatality and IG were indicated against SM. The basis of findings are SM was consuming alcohol the night before and possibly during the time of SC's death. Police found a beer which was still cold next to SC's bottle. All reports from Police and Hospital state SM had a strong odor of alcohol. Autopsy report states SC's cause of death as positional asphyxiation. SM admits to placing baby on his side in his bassinet due to congestion. SM found SC several hours later face down and not breathing. Mother has no other children in her care/custody. CW contacted reported contacting Florida, but did not obtain any case history records. It is unknown if the children were surrendered or parental rights were terminated. The report is closed.

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
Comments: Niagara County has an MDT that participated in this investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: Niagara County has an approved OCFS Fatality Review Team called a Rapid Response Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
025041 - Deceased Child, Male, 1 Mons	025043 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
025041 - Deceased Child, Male, 1 Mons	025043 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated

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:

Case notes and other obtained documentation appears to be entered timely.

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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: N/A							

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 siblings in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered, but were declined by subject mother.

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?	Yes
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 record of CPS reports in NYS involving subject mother or subject child more than three years prior to the fatality. Subject child reportedly has six siblings, but none that are members of this household. Subject mother reports having moved to Florida after high school and then returning to New York from Florida in March 2014. Subject mother reports having six other children and adopting two children. A male child whom resides with his father in NYS, a female child whom resides with her father in Florida. She reported she served three years in jail for kidnapping this female child from the father. Subject mother reported she does not have custody of any of her other children, but the detail of this are unknown and she refused to provide the children's names to the caseworker. She also claimed to have been a surrogate mother for a male child she then gave to a best friend. There are no details and there is no official documentation of these Florida children of reported events in the case record other than subject mother and family members reporting this information.

Known CPS History Outside of NYS

There is self-reported CPS history involving subject mother and 6-8 other children in Florida whom she reports none of which are in her custody, but the case record has no documentation regarding these children or reported events.

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

Additional Local District Comments

N/A

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