Child Fatality Report

Report Identification Number: BU-17-021

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

Issue Date: Jan 29, 2018

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 08/15/2017
Initial Date OCFS Notified: 08/15/2017

Presenting Information

An 8/15/17 SCR report stated the SM put SC to bed on 8/14/17 at approximately 11:30PM. When SM checked on SC the morning of 8/15/17 at approximately 10:30AM, she found SC unresponsive and SC was transported by ambulance to the hospital. There was a dresser in the bedroom where SC was found that was tipped over, but it was unclear how that occurred or if the dresser fell on top of SC. SC passed away on 8/15/17, but the cause of death was unknown. SC had been sexually and physically abused as she had rectal tears and strangulation marks around her neck. SM and SF did not have an explanation for SC's condition or injuries. SC did not have any known medical conditions. The conditions of the home were deplorable, but further details were unknown.

Executive Summary

Erie County Department of Social Services (ECDSS) began their investigation and coordinated efforts with LE upon receipt of this report. The investigation revealed that on 8/14/17, SM put SC to bed at approximately 11:30PM and did not check on her until 10:30AM the following morning. SM found the child lying face down with a dresser on top of her. SC was blue and SM immediately called 911 and performed CPR until first responders arrived. SC was transported to the hospital where she was pronounced dead at 11:50AM on 8/15/17. There were no surviving siblings.

An autopsy was performed and the manner of death was ruled an accident caused by accidental asphyxiation. ME found SC’s injuries to be consistent with the dresser falling onto the child. ME denied the presence of anal tears which were originally reported.

ECDSS obtained records from the hospital, SC’s pediatrician, LE, and FD. First responders described the home to be in deplorable condition which CW later verified during home visits. The condition of the home did not contribute to SC’s death but did pose a health and safety hazard to SC. CW interviewed all parties listed on the report as well as several collateral contacts, none of whom had any concerns with the parents' caretaking abilities. The family had no history with CPS and no criminal history.

Living in the home at the time of SC’s death were SM, SF, and MGM. At the time of SC’s death, SF had been out of state visiting relatives and returned upon learning of SC’s death. MGM and MU (who lived in the apartment below and occasionally watched SC) reported they had seen SC play with the dresser drawers and climb in them in the past. SF said it was not common for SC to play with the dresser and SM said SC was not really known to play with the dresser. SM did say SC would sometimes play with the handles and pull items out of the drawers.

ECDSS completed all safety assessments and fatality reports adequately and on time. ECDSS substantiated the allegations of IF/C/S and IG against SM, SF, and MGM and unsubstantiated all others. The report was indicated and closed on 10/13/17. ECDSS provided the family with grief and MH counseling resources.

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

Was the decision to close the case appropriate? Yes
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:
N/A

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: 08/15/2017 **Time of Death:** 11:50 AM

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

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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? 11 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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

On 8/15/17, ECDSS began their investigation and coordinated efforts with LE. CW verified the family had no CPS history. CW verified the information in the SCR report with source to be accurate.

CW went to the hospital where SC was taken and spoke with the hospital social worker who said staff worked on SC when she arrived but they could not revive her. CW met with Buffalo Police Department at the hospital and they allowed CW to view SC's body. A nurse went in the room with CW and pointed out marks on SC's chin and bruises on her legs. CW took a few pictures of SC's face, neck, and legs.

CW then met in a family conference room with SM, MGM, and MU. SF had been out of state visiting relatives for the last week but was on his way home. SM said on 8/14/17, since SC went to bed later than usual, around 11:30PM, she allowed her to sleep in later on 8/15/17. MGM left for work at 6:30AM and did not see SC before she left. SM went into SC's bedroom around 10:30AM, found her not breathing with a dresser on top of her. SM screamed and MU and his fiancé ran up to her apartment. This was the first time SM checked on SC after putting her to bed the night before. SM denied hearing the dresser fall at any point. MU who lived downstairs denied hearing a dresser fall. MU said he went for a walk with his roommate from approximately 9-10AM that day. A pastor then came in the room and offered SM services. SM recounted the same story of what happened to the pastor. At a later interview, SM said when she found SC, she was face down on the floor and blue. The dresser was on top of SC. SC's neck was stuck on the middle drawer and the top drawer was on top of SC. SM picked up the dresser and flipped SC over. SM called 911 who gave CPR instructions which SM started. First responders arrived shortly after and Buffalo Fire Department workers took SC outside and continued CPR, and then transported SC to the hospital.

CW met with the attending Dr. at the hospital who said when SC arrived at the hospital, staff worked on her for approximately 25 minutes and she was pronounced dead at 11:50AM.

CW interviewed SM, SF, MGM, MU, MU's fiancé, MU's 2 roommates, SC's babysitter and his fiancé, all of whom had no concerns of any abuse or maltreatment of SC by any of the caretakers. SM, SF, and MGM denied any drug/alcohol abuse or domestic violence in the home. The collaterals stated SM and SF are good parents and took good care of SC.

CW spoke with LE, EMS, and FD who were present the day of the incident, all stated the home was in deplorable condition. The home was reported to have animal feces on the floors, very cluttered, a full litter box in the bathroom, dirty dishes piled high in the sink, a strong foul odor in the home, and a hole in the screen of SC's window which was open. CW

observed the same conditions upon home visits.

CW spoke with ME who definitively denied SC having anal tears and that the injuries were consistent with SC having a dresser fall on top of her and being pinned beneath. ME said SC had bruising on her leg that is normal for a toddler and the mark on her neck corresponds with SC being wedged between drawers. SC died from accidental asphyxiation and it is plausible SC did not scream due to drawers compressing her neck and airways.

CW obtained records from FD, LE, medical records from the hospital and SC's pediatrician. No criminal history was found for the family. DA and LE did not press criminal charges in this case as they felt it was accidental.

The family was provided information on grief counseling and grief support groups. SM said she sometimes suffers from minor MH issues and SF said he was diagnosed with MH issues when he was a teenager. Neither were in treatment or on medication. CW provided SM and SF with MH resources available to them.

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
043463 - Deceased Child, Female, 2 Yrs	043466 - Grandparent, Female, 50 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
043463 - Deceased Child, Female, 2 Yrs	043464 - Mother, Female, 23 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
043463 - Deceased Child, Female, 2 Yrs	043464 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
043463 - Deceased Child, Female, 2 Yrs	043465 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
043463 - Deceased Child, Female, 2 Yrs	043465 - Father, Male, 24 Year(s)	Sexual Abuse	Unsubstantiated
043463 - Deceased Child, Female, 2 Yrs	043464 - Mother, Female, 23 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
043463 - Deceased Child, Female, 2 Yrs	043464 - Mother, Female, 23 Year(s)	Sexual Abuse	Unsubstantiated
043463 - Deceased Child, Female, 2 Yrs	043465 - Father, Male, 24 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
043463 - Deceased Child, Female, 2 Yrs	043465 - Father, Male, 24 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated

043463 - Deceased Child, Female, 2 Yrs	043465 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
043463 - Deceased Child, Female, 2 Yrs	043464 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
043463 - Deceased Child, Female, 2 Yrs	043466 - Grandparent, Female, 50 Year(s)	Inadequate Guardianship	Substantiated
043463 - Deceased Child, Female, 2 Yrs	043465 - Father, Male, 24 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
043463 - Deceased Child, Female, 2 Yrs	043464 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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

Additional Local District Comments

We at the Erie County Department of Social Services (ECDSS) find that the facts as written describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that ECDSS' response to the fatality was conducted appropriately and that there are no required actions related to the fatality. We appreciate the opportunity to partner with OCFS in providing the best possible services to families in our community.

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