Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-17-031

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

Issue Date: Feb 15, 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: 10 month(s)
Jurisdiction: Seneca
Gender: Male
Date of Death: 08/20/2017
Initial Date OCFS Notified: 08/20/2017

Presenting Information

An SCR report was received alleging on 8/19/17, at around 9PM, SF put SC to bed. At that time, SC was co-sleeping in bed with his 9-year-old and 6-year-old SS. On 8/20/17, at about 1:10AM, SF checked on SC and found him to be unresponsive, while still in bed with the SS. SM immediately called 911, and EMS responded to the home. The SC had no known preexisting medical conditions.

Executive Summary

This fatality report concerns the death of a 10-month-old male (SC) that occurred on 8/20/17. A report was made to the SCR on that same date, with allegations of DOA/Fatality and IG against SM and SF regarding SC. Seneca County Department of Social Services (SCDSS) conducted an investigation surrounding SC's death. An autopsy was performed; however, at the time of this writing, the final report had not yet been released, and the cause and manner of death remained pending.

SC was considered to be a healthy child at the time of his passing and was not diagnosed with any preexisting medical conditions or ongoing medical concerns. SC resided with SM, SF, and his six SS, ages 13, 12, 10, 9, 7, and 2 years old. It was discovered SC was put down to sleep on his back in an adult queen-sized bed at approximately 8:30PM the night of 8/19/17; he was placed on the middle of two pillows. Later, the 9- and 6-year-old SS went to sleep in the same bed, on either side of SC. According to LE, at approximately 1AM, SF awoke to use the bathroom and check on the children, as was his normal routine, and found SC unresponsive. SF attempted resuscitation efforts and called 911. SC was transported via ambulance to the hospital, and was pronounced deceased at 2:22AM.

It was reported SC would sleep in an adult bed with SS or SM and SF regularly since the time he was 6 months old, despite there being appropriate sleeping provisions in the home available to SC. It is unclear in the case record if the parents were previously educated surrounding safe sleep practices. From the time the investigation began to the time of its closure, SCDSS met with and interviewed SM, SF, and all verbal SS, assessed the home environment, and followed up with collateral sources. SCDSS substantiated all the allegations in the report, and noted the parents failed to provide a minimal degree of care by placing SC in an unsafe sleep environment, which in turn led to his death. Upon review of this fatality investigation, OCFS found there was insufficient evidence collected to support the allegations. Although SC was placed in an unsafe sleep environment, there was no evidence to support this caused his death, and further evidence was needed to show causation.

PIP Requirement
Review of this investigation resulted in citations related to casework practices. In response, SCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) SCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, SCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** No

Explain:
Although SCDSS found some evidence to support the allegation of IG, there was insufficient evidence found to substantiate the allegation of DOA/Fatality.

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:
The case activities were commensurate with the case circumstances. The decision to close the investigation was appropriate, as there were no safety concerns for any of the SS.

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:	Many progress notes were entered one month or more, after their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	SCDSS will enter progress notes contemporaneously as events occur.
Issue:	Appropriateness of allegation determination
Summary:	SCDSS did not gather evidence to substantiate the allegation of DOA/Fatality. Although child was placed to sleep in potentially unsafe environment, there is no evidence this caused the death.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	Per OCFS-LCM-01, if the ME does not opine on causation, CPS must consult with other professionals for their opinion on causation; or witnesses otherwise familiar with circumstances.

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	SCDSS did not address concerns the CHN were using farm equipment that may be unsafe, overdue medical needs, a cord and "dirty pipe" found in bed with SC and the SS, or if SM and SF were educated regarding safe sleep prior to SC's death.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	SCDSS will explore all concerns fully when they arise during an investigation, and will conduct complete and adequate investigations.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30 Day Fatality Report was due on 9/19/17, but not completed and approved until 9/22/17.
Legal Reference:	CPS Program Manual, VIII, B.2, p.4
Action:	SCDSS will complete the 30 Day Fatality report within 30 days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect that SCDSS contacted the older SS's schools as a collateral contact.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	SCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/20/2017 **Time of Death:** 02:22 AM

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

County where fatality incident occurred: Seneca
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? 4 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	Male	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)

LDSS Response

On 8/20/17, SCDSS received a report regarding the death of SC. SCDSS initiated their investigation within 24 hours, and coordinated their efforts with LE. SCDSS contacted the source of the report, and found the family had no prior CPS history. SCDSS spoke with LE, who informed SCDSS SF had woken up in the middle of the night to check on SC, and that is when he found SC unresponsive, immediately called 911 and attempted CPR.

SCDSS completed an initial home visit on the date the report was received, and learned SC resided with SM, SF, and six SS (ages 13, 12, 10, 9, 7, and 2 years old). Safety of the home was assessed and no concerns were noted. A Pack and Play was observed with a small blanket inside of it, and all the other children had appropriate sleeping arrangements. The following day, SCDSS and LE again went to the family's home and completed interviews with SM, SF, and the verbal SS, as well as a reenactment of what occurred. There was nothing indicated that the sleep environment was the cause of SC's death. SM and SF denied SC was ill in the days leading up to his death, and that anything out of the ordinary occurred that night. Both parents reported SC was put to sleep in a queen-sized bed at approximately 8:30PM on 8/19/17. It was discovered it was normal practice for SC to sleep in an adult bed with either SM and SF, or the 6- and 9-year-old SS. On the night in question, SC was placed on his back to sleep, on the middle of two pillows. When the 6-and 9-year-old SS went to bed later that night, SC remained asleep and was in the middle of the two children; the other SS slept in their own rooms. All the SS stated SC was very mobile, and would hit, kick and push SS if they got too close to him during the night; however, the night of SC's death, neither of the SS in bed with him reported recalling any movement. None of the children reported any safety concerns in the home.

The record did not reflect if SM and SF were previously educated surrounding safe sleep practices, but the CW did educate the parents of such during the fatality investigation. Interviews with the SS revealed SC was normally placed to sleep on his back in an adult bed, with his SS or with SM and SF.

During the initial stages of the investigation, LE noted concerns that the cord to a box fan ran under the pillows in which SC and the two SS slept upon, and that a "dirty" plastic tube, believed to be from a toy or a piece of farm equipment, was found in their bed. Further, a relative reported a concern that some of the SS were allowed to use farming equipment that

may create an unsafe situation. The pediatrician reported the 2-year-old SS had not been seen since 2014, and they had no medical information regarding the 7-year-old SS; exams were "refused". The pediatrician also reported the 9-year-old SS was last seen in 2013, there were no immunization records, and all further exams were "refused". SCDSS did not follow up with the family regarding any of these concerns during the course of their investigation..

SCDSS contacted collateral sources, which included the children's pediatrician, hospital staff, LE, the ME, and family members. Home visits were made and interviews with all individuals named on the report were completed. At the close of the investigation, all of the SS were deemed as safe. No criminal charges were brought against either parent. The results of the autopsy remained pending at the time of this writing. SCDSS indicated all allegations in the report and closed the case. SCDSS noted in the determination the parents failed to provide a minimal degree of care by placing SC in an unsafe sleep environment, which in turn led to his death.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or 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
Comments: The fatality investigation was conducted by the Seneca County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Seneca County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
043642 - Deceased Child, Male, 10 Mons	043650 - Father, Male, 32 Year(s)	DOA / Fatality	Substantiated
043642 - Deceased Child, Male, 10 Mons	043650 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
043642 - Deceased Child, Male, 10 Mons	043649 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
043642 - Deceased Child, Male, 10 Mons	043649 - Mother, Female, 32 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
School	☐	☒	☐	☐
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:

SCDSS contacted collateral sources and interviewed all individuals named on the report. Many progress notes were entered one month or later after their event dates. The record did not reflect if the SS' schools were contacted.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐

Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
None of the SS were removed as a result of this fatality report or for reasons unrelated. There was no discussion with the parents surrounding the children's safety when using of farm equipment.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
SCDSS offered the family grief and counseling services, but the family declined. The family may have benefited from assistance with funeral arrangement, or family planning services, but neither were offered. SM and SF reported the use of their church, family, and friends as supports to help them through their grieving.

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? No
Explain:
Grief counseling was offered to all of the SS as a result of the fatality, but declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Grief counseling was offered to SM and SF as a result of the fatality, but declined. The parents reported they had begun to receive counseling through their church.

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 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 New York State.

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