Child Fatality Report

Report Identification Number: SV-18-050

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

Issue Date: Jan 03, 2019

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		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 08/26/2018
Initial Date OCFS Notified: 08/27/2018

Presenting Information

An SCR report alleged the SC was pronounced deceased on 8/26/18 at 12:31PM. She was in the care of her maternal aunt. The aunt fed the infant, burped her, and laid her down for a nap in a Rock and Play, propped with a pillow, around 9AM. At 11:35AM, 911 was called and shortly thereafter, police arrived and found the aunt performing CPR. It was unknown what occurred between 9AM and the time 911 was called. The report further noted the infant was born addicted to opiates due to her mother's drug abuse; however, the child was considered otherwise healthy at the time of her death. The child's grandmother had an unknown role.

Executive Summary

This fatality report concerns the death of a 2-month-old female (SC) that occurred on 8/26/18. An SCR report was made on that date, with concerns the death might have been related to unsafe sleep. There were additional allegations against the mother, regarding the child being born addicted to drugs.

Orange County Department of Social Services (OCDSS) and LE conducted investigations of the fatality. OCDSS promptly interviewed collaterals and caregivers, and arranged for a safety assessment of the surviving sibling and other children in his home; the sibling resided in Pennsylvania. Upon assessment, no safety concerns were revealed for those children. The MGM had primary custody of the SC due to mother's drug use and subsequent incarceration. The maternal aunt was the SC's caregiver at the time of the fatality; she cared for her on a regular basis.

OCDSS collaborated with investigators from the ME's office and LE. The investigation revealed the aunt placed the SC to sleep in a bassinet atop a plush pillow, positioned on her side. The aunt said the SC's pediatrician advised her to prop the baby at night, and she thought she was following the Dr.'s advice. She told OCDSS she was educated by the pediatrician about safe sleep practices, but reported the SC was placed to sleep in that manner since she came home from the hospital. She further noted the SC would not sleep on the bassinet mattress, as it was "thin." At the onset of the investigation, LE verbally informed OCDSS the aunt reported the pillow was over the SC's mouth. LE obtained a written statement from the aunt. She reported finding the SC unresponsive in the bassinet, with her face against the pillow, her nose partially exposed.

OCDSS gathered documentation of the SC's pediatrician appointments since birth. The aunt brought the SC to most appointments. OCDSS spoke with a medical professional at the pediatrician's office regarding the alleged advice about propping. OCDSS was informed their practice routinely recommended an infant's mattress be elevated if suffering from a certain condition, like the SC. The professional reported it was always specified that elevation was to come from underneath a mattress.

OCDSS spoke with the Medical Examiner on 9/5/18 and documented the Medical Examiner said the death was consistent with asphyxia at that time. OCDSS documented the preliminary autopsy report completed 9/26/18 noted the same concern for asphyxiation. The question of causation was not discussed with other medical providers. The final autopsy report was not complete at the time the investigation was determined.

Even though OCDSS unsubstantiated all allegations, the record reflected there was some credible evidence to substantiate the allegation of inadequate guardianship against the maternal aunt. The investigation conclusion noted the aunt had misunderstood the directive of the doctor about how to elevate the child for sleep, and believed she was acting in the best

interest of the child. However, the contents of the sleeping area in which the aunt placed the child created an unsafe condition for a child of such age and developmental vulnerability, thus placing her in immediate danger of serious harm.

After LE's investigation, no criminal charges were filed, nor were there any arrests related to the fatality.

Once received, OCDSS forwarded the final autopsy report to OCFS. The cause of death was, "Undetermined (infant found unresponsive in bassinet with plush pillow and multiple blankets)." The manner of death was "Undetermined."

The aunt initially accepted services from Orange County's Special Assistance Trauma Unit, then later sought her own counseling services. The CW in Pennsylvania offered supports to the children, but a need for services was not identified. It did not appear an offer was extended to the grandmother. The father identified having familial supports, and the mother received counseling in jail.

PIP Requirement
OCDSS will submit a PIP to the Spring Valley Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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:**
  - **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:
OCDSS unfounded all the allegations in the report, despite there being evidence documented to support substantiating inadequate guardianship.

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:
Casework activity was commensurate with case circumstances, and 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:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	Based on the information gathered, OCDSS had some credible evidence to substantiate the allegation of inadequate guardianship, though the allegation was unsubstantiated and the report was unfounded.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	OCDSS will refer to the CPS Program Manual and/or consult with the Spring Valley Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/26/2018 **Time of Death:** 12:31 PM

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 11:35 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? 90 Minutes
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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	58 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Other Household 1	Mother	Alleged Perpetrator	Female	28 Year(s)
Other Household 2	Father	No Role	Male	44 Year(s)
Other Household 3	Grandparent	No Role	Female	53 Year(s)
Other Household 3	Sibling	No Role	Male	7 Year(s)

LDSS Response

OCDSS immediately responded to the report by reviewing history, contacting collaterals, and interviewing family members. OCDSS requested out-of-state CPS records when it was learned the SC, her mother, and surviving sibling had history in Pennsylvania. A request was made on the date of the report that the Pennsylvania Council of Children, Youth, and Family Services (PCCYFS) assess the safety of the 7-year-old sibling in his home, where he resided with the maternal grandmother.

OCDSS learned the maternal aunt had been caring for the SC in her home most of the child's life, as the SC's parents were incarcerated. The aunt attended the SC's medical appointments, and stated she was told by the pediatrician she could prop the child while she slept, though she did not specify how she was advised to prop. She told OCDSS she was advised of safe sleep practices by the pediatrician. The maternal grandmother later told OCDSS she believed neither she nor the aunt had received safe sleep education.

Hospital staff suspected the aunt was impaired on an unspecified substance at the time she presented at the hospital, but OCDSS and LE did not have the same observation. The aunt described the events as such: She said the SC had difficulty sleeping throughout the night, and the SC ate her last bottle between 8 and 9AM. She then placed the SC to sleep for a nap on a pillow, positioned on her side, in a bassinet. The aunt also took a nap and awoke between 10:40AM and 11AM, at which time she checked on the SC and found her unresponsive. Though she didn't provide OCDSS with a description of how the SC was found, LE relayed to OCDSS that the aunt previously told them the SC was found with her face against the pillow, the pillow covering her mouth, and her nose partially exposed. The uncle who resided in the home was in another room at the time of the incident.

OCDSS viewed the incident location with LE, and observed a pillow and receiving blanket in the bassinet. LE explained the blanket observed had been used to prop the SC. OCDSS documented in the case record that although there were some tests still pending, the Medical Examiner described the death as consistent with asphyxia. OCDSS viewed a recorded doll reenactment, though the observations were not noted. The toxicology screening results showed the SC had no drugs or medications in her system at the time of death.

OCDSS gathered information from PCCYFS regarding their safety assessment of the sibling and MGM's two minor children. The assessment was conducted on 8/31/18, and all children were interviewed. No concerns were revealed, and PCCYFS ended their involvement shortly thereafter.

OCDSS spoke by phone with the SC's mother and father when face-to-face interviews were unable to be made. At the time of the interviews, both parents resided in Pennsylvania – the mother in jail, and the father in a halfway house. The parents specified they had their own supports in response to the death of their child. The father indicated he had another child, to whom he had given up his parental rights approximately 5 years prior.

Based on the information gathered, OCDSS had some credible evidence to substantiate the allegation of inadequate guardianship, based on the imminent danger in which the aunt placed the infant, though the report was unfounded. LE spoke to how the SC was found based on the aunt's description; OCDSS observed the unsafe sleep environment (a bassinet which contained a pillow and blanket); and, the Medical Examiner verbalized concern for asphyxiation. OCDSS described having gathered no credible evidence to link the unsafe environment to the cause of death. OCDSS concluded their involvement with the family when appropriate, and made service referrals to the family members residing in New York State.

Official Manner and Cause of Death

Official Manner: Undetermined
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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was reviewed by the Orange County Child Fatality Review Team in September, 2018.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048320 - Deceased Child, Female, 2 Mons	048321 - Aunt/Uncle, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
048320 - Deceased Child, Female, 2 Mons	048323 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
048320 - Deceased Child, Female, 2 Mons	048321 - Aunt/Uncle, Female, 32 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?	☒	☐	☐	☐

Additional information:
When the parents could not be interviewed face-to-face given their locations, they were interviewed over the phone.

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 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	☒	☐	☐	☐

Explain:
The maternal aunt accepted services for a period of time. The maternal grandmother, sibling, and the grandmother's children resided out of state; it was not noted whether CPS in Pennsylvania provided services to them.

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:
No children needed to be removed.

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:
The maternal aunt accepted assistance from the Special Assistance Trauma Unit, who continued to make referrals for the family. The mother reported she engaged with mental health services in her jail. The funeral and services appeared to have taken place out of state.

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:
PCCYF asked the children if they felt they needed additional supports regarding their loss, and the children identified their family provided the support they needed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The maternal aunt accepted Special Assistance Trauma Unit services in response to the fatality. A referral for this service was made for the family. Services were discussed with the parents; the father reported to have his own supports and the mother said she used mental health services in her jail.

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 in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

On 5/11/18, the Pennsylvania Council of Children, Youth, and Family Services (PCCYS) investigated a report with allegations of the SM's drug use in the home with her son (SS) present. The SS was found to be safe. During the investigation, SC was born with a positive toxicology. The SM self-reported to hospital staff she used 10 bags of heroin a day. The SC suffered withdrawal and had an extended stay in the hospital as a result; the SM left the day after the SC was born, against medical advice. The SM disclosed to PCCYS her continued use of the drug, and there were concerns for the BF's use as well. PCCYS devised a safety plan with the parents for the SC to be temporarily cared for by the PGM upon her discharge from the hospital; the MGM stated her medical issues precluded her from the ability to care for the infant full-time. On 6/16/18, the SM was arrested on drug charges, and SF brought the SC to the MA's house to be cared for. The next day, the SF was arrested as well. PCCYS visited the MA's home and spoke with the MA and MU about being resources for the child. The maternal relatives inquired about custody arrangements for the SC, and PCCYS advised them to petition the Court themselves, as PCCYS did not have custody. It appeared the case was closed shortly thereafter; a determination was not noted. Although living arrangements were assessed at each home where the SC stayed, there was never any documented discussion about safe sleep.

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

Orange County disagrees that there is sufficient credible evidence to support a determination of inadequate guardianship due to unsafe sleep. In reviewing the regulations regarding safe sleep, there must be existence of three things. Impairment or imminent danger of impairment of the child's condition, failure to exercise a minimum degree of care and that failure CAUSED the impairment. While there was evidence of the first two, the medical examiner ruled the death "undetermined". Although asphyxiation was mentioned early on, there was no medical evidence to support this theory and the findings of the autopsy indicates that the child may have had a viral syndrome and had pulmonary congestion. The medical examiner did not state that there was "causation between the actions and inactions" of the guardian and therefore causation has not been satisfied. Additionally, there is concern that a guardian's choice to share a bed or provide soft covering for an infant in a bassinet is similar to a choice for a guardian to let a child ride a bike, ski, snowboard, swim in the ocean or any other potentially risky activity. If a child becomes injured or dies during those activities while supervised, there would not even be a CPS report. We have concerns about where the line is drawn regarding the issues of safe sleep and how it relates to the definition of neglect.

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