Child Fatality Report

Report Identification Number: AL-16-013

Prepared by: Albany Regional Office

Issue Date: Aug 02, 2017

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		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Washington
Gender: Male
Date of Death: 06/28/2016
Initial Date OCFS Notified: 06/28/2016

Presenting Information

On 6/28/16, mother was nursing her two month old subject child in bed. Mother fell asleep and father woke up sometime later to find deceased child wedged between mother's breast and a nursing pillow. Child was unresponsive. Great grandmother called 911 and aunt attempted CPR. 911 was called and subject child was taken to hospital where child was pronounced dead.

Executive Summary

A SCR report dated 6/28/16 alleging DOA/Fatality and IG by the mother and father. On 6/28/16 WCDSS immediately initiated an investigation with law enforcement. WCDSS in collaboration with law enforcement conducted interviews with father, mother, hospital/medical staff and other family members regarding the death of the subject child. Notifications were made to NYS OCFS and the District Attorney's Office. Although the report did not meet the criteria for a Multidisciplinary Team fatality lead investigation, the MDT was notified and reviewed the report at a later date. WCDSS gathered information from law enforcement, emergency medical personnel, hospital staff, the pediatrician and medical records and other family members.

Case record does not reflect the mother or father were informed of the dangers of co-sleeping. The mother reported she had been breastfeeding child at 6AM and had propped child in the boppy pillow on the bed next to her. Mother reported she fell asleep and doesn't remember anything after that. She reported the child's father woke her up and said the child wasn't breathing and he couldn't find a heartbeat. The father reported mother fell asleep while breastfeeding child during the early morning hours of 6/28/16. The father awoke to find the mother's breast and nipple partly over the baby's face and mouth while the baby lay in a "boppy" pillow next to her. The baby was unresponsive and the mother and father yelled for help and brought the baby downstairs where other family members lived. A family member immediately called 911 at 8:37PM while another family member administered CPR. Emergency medical personnel arrived at 8:45AM. Attempts to revive the baby were unsuccessful by family and emergency medical personnel and the child was pronounced deceased at the hospital at 9:30AM on 6/28/16. The mother and other family member's account of the events were consistent with the mother and father's report.

Although toxicology reports are still pending, there was no evidence that drugs or alcohol played a role in the subject child's death. There was no indications suggesting the death was anything other than accidental. Subject child was born a twin, however the twin passed away in utero shortly before deceased child was born. There is no surviving siblings in the home. WCDSS offered supportive services information, including grief and loss counseling to the family.

NYS Police determined the death to be accidental and closed their investigation. No criminal charges were filed. WCDSS concluded the investigation and determined there is no credible evidence to substantiate the allegation of DOA/Fatality and IG against the mother and father. On 8/8/16 the report dated 6/28/16 was unfounded and closed.

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:
Report was closed as there were no surviving siblings.

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: 06/28/2016 **Time of Death:** 09:30 AM

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

County where fatality incident occurred: Washington
Was 911 or local emergency number called? Yes
Time of Call: 08:37 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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

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

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)

LDSS Response

LDSS and NYS police conducted a joint investigation on the report dated 6/28/16 that alleged DOA/Fatality and Inadequate Guardianship of deceased child. LDSS and police conducted interviews with father, mother, grandmother, aunt, hospital/medical staff and other family members. LDSS reviewed medical and first responder records and made home visits to case address. Evidence supports that the sudden death of subject child to be accidental. Toxicology reports and official autopsy are still pending. No indications suggesting the death was anything but accidental. LDSS responded to information immediately by contacting law enforcement, the District Attorney's office and proceeded to assess safety immediately.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: No official yet

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No

Comments: Fatality investigation was not conducted by MDT as this was not an open services case. MDT was informed and met later to review the case.

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
032025 - Deceased Child, Male, 2 Mons	032027 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated

032025 - Deceased Child, Male, 2 Mons	032027 - Father, Male, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
032025 - Deceased Child, Male, 2 Mons	032026 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
032025 - Deceased Child, Male, 2 Mons	032026 - Mother, Female, 21 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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	Offered,	Offered,	Needed	Needed	N/A	CDR

	After Death	but Refused	Unknown if Used	but not Offered	but Unavaliable		Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☒	☐	☐	☐	☐	☐
Funeral arrangements	☐	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
Services were offered to family by LDSS for counseling services and funeral expensive referrals. Both services were refused by family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered to family by LDSS for counseling services and funeral expensive referrals. Both services were refused by family.

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

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

N/A

Known CPS History Outside of NYS

N/A

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.

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