NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-15-008 **Prepared by: Buffalo Regional Office**

Issue Date: 2/5/2016

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: Erie
Gender: Male
Date of Death: 02/23/2015
Initial Date OCFS Notified: 02/23/2015

Presenting Information

"Today the mother and father were up with the child, age six weeks, at 2:00am to feed the child. The mother and father put the child to sleep in bed with the mother while the father slept on the floor. When the mother and father woke up at approximately 7:00am, the child was unresponsive in bed and had blood around his mouth. The child was pronounced dead at Women and Children's Hospital upon arrival at 8:00am. The child had no known prior medical issues and was an otherwise healthy child."

Executive Summary

The ECCPS received a fatality report from the SCR on 2/23/15 regarding the subject child (SC). The report contained allegations of DOA/Fatality of the SC and named both parents as subjects. The report stated that the parents fed the SC at 2:00am on the date of the report and then laid him down to sleep with the mother on her bed. When the parents woke up at 7:00am the SC was unresponsive and had blood around his mouth. The SC was pronounced dead on arrival at the hospital at 8:00am. The SC was a healthy child with no known medical issues.

ECCPS conducted an appropriate investigation that included contact with the source, police, medical examiner, EMS, fire department, hospital, child's pediatrician, refugee services, perinatal bereavement services and all family members. Appropriate safety and risk assessments were completed. The family did not speak English. ECCPS arranged for and utilized interpreter services for contacts with the family throughout the investigation.

All first responders stated that the parents described that they had fed the SC at 2:00am and laid him down on his back on the mother's bed which was a full size mattress on the floor and up against the wall. The parents stated that the SC was swaddled in a blanket as they were shown at the hospital when the SC was born. The parents denied that the blanket was covering the SC face or that the SC was pressed against the wall. The parents said that the SC was found in the same position that they laid him down in. The father (FA) slept on the floor next to the bed. The mother (MO) said that the SC was not ill and had been seen by his pediatrician on 2/20/15 and was healthy. The MO said that she woke up at approximately 7:00am and found the SC unresponsive and cold to the touch with blood on his face and his mouth. The FA called 911 at 8:18am and then attempted to warm the SC by rubbing his legs and feet. The PGM assisted in trying to warm the SC. The fire department was first on scene and attempted CPR on the SC. Once the ambulance crew arrived the SC was transported to Women and Children's Hospital where he was pronounced dead at 8:48am.

ECCPS made referrals for perinatal bereavements services and for assistance with funeral expenses. An interpreter was used to review and provide safe sleep information with the parents.

At the time the investigation was closed the Erie County Medical Examiner had not yet issued an autopsy report and stated there were no preliminary findings.

ECCPS unsubstantiated the allegations and unfounded the report on 4/21/15 as there were no preliminary autopsy results and no aggravating conditions were present in the circumstances of the child's death.

The Erie County Medical Examiner issued a final autopsy report in regard to the child on May 21, 2015 which listed the Cause of Death as Positional Asphyxia and the Manner of Death as Accident. The opinion statement was that death was attributed to asphyxia in an unsafe sleep environment.

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:
Casework activity was appropriate for case circumstances.

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:
Case closing was appropriate. There are 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: 02/23/2015 **Time of Death:** Unknown

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 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: Not impaired.

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	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	82 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	71 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	55 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	17 Year(s)

LDSS Response

ECCPS received a report from the SCR on 2/23/15 naming the MO and FA as subjects and containing allegations of DOA/Fatality of the child, age six weeks. The report alleged that the parents had fed the child at 2:00am and laid him down to sleep in bed with the MO. At 7:00am the MO found the child unresponsive.

ECCPS conducted an appropriate investigation into the fatality. Contact was made with the family on the date of the report. The family does not speak English. Interpreter services were arranged for and utilized throughout the investigation for all contacts with the family. Appropriate safety and risk assessments were completed timely.

ECCPS contacted and interviewed the source of the report, police, fire department, EMS, Emergency Room and social work staff at the hospital, the child's pediatrician, Medical Examiner, refugee service agency, parents and family members.

Both parents said that they had stayed up late the night before the child's death playing with and feeding the child. They said they had fed the child a bottle at 2:00am and laid him down to sleep with the mother as usual. The MO said the child was swaddled in a blanket as she was shown at the hospital and laid on his back on her bed between her and the wall. The

bed was a full sized mattress which was placed against the wall. The FA slept on the floor next to the mattress. The MO said the child was not up against the wall and the blanket was not covering his face. Both parents said that the child had previously slept in the pack and play until 15 to 20 days prior when he became bigger and they began putting him to sleep in bed with the MO. The parents said they went to sleep around 2:00am after feeding the child. The MO said she woke up at approximately 7:00am and found the child unresponsive with blood coming from his nose. The MO said the child was still on his back swaddled in the blanket just as she had laid him down. The MO said the child was cold and lifeless to the touch. The FA and PGO tried to warm the child by rubbing his legs and feet. The FA called 911 at 8:18am and when the fire department arrived they began CPR. EMS took over CPR when they arrived and transported the child to the hospital where he was pronounced dead at 8:48am. All family members gave consistent accounts of the events of the day the subject child died.

ECCPS made referrals for the family for assistance with funeral costs, grief counseling and utilized an interpreter to review safe sleep information with the parents.

ECCPS unsubstantiated the allegations and unfounded the report on 4/21/15 based on no preliminary autopsy results and there being no aggravating conditions present in the circumstances of the child's death.

The Erie County Medical Examiner issued a final autopsy report in regard to the child on May 21, 2015 which listed the Cause of Death as Positional Asphyxia and the Manner of Death as Accident. The opinion statement was that death was attributed to asphyxia in an unsafe sleep environment.

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: ECCPS coordinated their investigation with law enforcement

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Erie 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
023522 - Deceased Child, Male, 1 Month(s)	023521 - Mother, Female, 17 Year(s)	Inadequate Guardianship	Unsubstantiated
023522 - Deceased Child, Male, 1 Month(s)	023523 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated

023522 - Deceased Child, Male, 1 Month(s)	023521 - Mother, Female, 17 Year(s)	DOA / Fatality	Unsubstantiated
023522 - Deceased Child, Male, 1 Month(s)	023523 - Father, Male, 24 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:
N/A

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: safe sleep education provided with an interpreter							
Additional information, if necessary: Referrals were made for bereavement counseling and for assistance with burial costs for the family. The caseworker arranged for an interpreter in order to review safe sleep information in detail with the family.							

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 are no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Referrals for assistance with funeral expenses and grief counseling were given to the 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/25/2014	6816 - Mother, Female, 16 Years	6817 - Father, Male, 23 Years	Inadequate Guardianship	Unfounded	Yes
	6816 - Mother, Female, 16 Years	6818 - Grandparent, Female, 54 Years	Sexual Abuse	Unfounded	

Report Summary:
ECCPS received a report from the SCR on 6/25/14 naming the father (FA), age 23, and his mother as subjects alleging SA and IG of the mother (MO) age 16. The report stated that the FA and MO were in a sexual relationship that both their parents were aware of, agreed to and that MO was pregnant. ECCPS did an investigation and found that the MO had moved to Buffalo from Rochester, NY to live with the father in the fall of 2013 and that both Mo and FA's parents agreed to this plan because MO and FA planned to marry when MO was 18yo. The MO refused to attend school when living with her parents and agreed to attend if allowed to live with FA. MO was pregnant with the subject child.

Determination: Unfounded | **Date of Determination:** 08/22/2014

Basis for Determination:
ECCPS unsubstantiated the allegations and unfounded the report on 8/22/14 due to the MO denying that she was forced to live with the FA, no evidence of human trafficking was present, her parents agreed to let her move to live with FA and

were aware of the relationship, the family's plan for the MO and FA to marry when the MO was 18yo and that the police declined to pursue criminal charges.

OCFS Review Results:

OCFS review of the case record found that there was credible evidence that the FA had a sexual relationship with the MO despite her age of 16yo and his age of 23yo and that both of their parents were aware and agreed to the relationship as there was a plan for the FA and MO to marry when the MO became 18yo. In addition the MO stated she would attend school if allowed to live with the FA. The FA and MO shared a bed at both of their parents' homes and the mother was pregnant at the time of the investigation. The determination made by ECCPS to unsubstantiated the allegations and unfound the report was incorrect based on the evidence gathered during the investigation.

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

Issue:

Appropriateness of allegation determination

Summary:

ECCPS unsubstantiated the allegations and unfounded the 6/25/14 SCR report on 8/22/14 when some credible evidence existed that the allegations of sexual abuse and Inadequate Guardianship were true and that the MO, age 16, was living with the FA, age 23, with their knowledge and consent and that the MO was pregnant. The MO's parents were incorrectly given no role on the report.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(c)

Action:

ECCPS must correctly evaluate and apply information gathered during the investigation to the definitions of abuse and maltreatment when making determinations for all SCR reports. ECCPS must correctly identify persons legally responsible for the child and subjects for all SCR reports.

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

N/A

Known CPS History Outside of NYS

None.

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

Thank you for allowing us the opportunity to review the report in advance. ECDSS finds that the facts are as stated and we are satisfied that it accurately describes the unfortunate event and actions taken.

We note that when the reviewer assessed the CPS investigative history covering the three year period preceding the fatality, it was discovered that the report dated June 25, 2014 (which was not the fatality report) was determined incorrectly and a distinction of "no role" was given to caretakers for the child. We share the concerns identified, and they will be addressed with the individual workers and supervisors involved in the case. Additionally, all required actions will be communicated to program supervisors and line staff. Program Administration will ensure compliance.

Additionally, we agree with the reviewer's assessment and recommended action directed toward the hospital where the subject child was born, suggesting that the hospital provide written materials on safe sleep to non-English speaking parents in the parents' native language. While we have no jurisdiction over the hospital and their policies, the Erie County Department of Social Services (ECDSS) will direct our hospital co-located CPS caseworker to speak with hospital administration regarding their ability to provide safe sleep materials to parents in their native language or to utilize an interpreter when reviewing safe sleep practices with non-English speaking parents. Additionally, our hospital caseworker will advise hospital administration of OCFS' recommendation with respect to this matter, utilizing the hospital's Child Fatality Review Team representative as a conduit for the communication. We would like to point out that ECDSS was not active with the family at the time of the child's birth, but that an Erie County CPS caseworker did discuss safe sleep practices with the parents, utilizing an interpreter, in August 2014 (during the mother's pregnancy). This discussion is documented in the Connections record.

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

Explain: Written materials on safe sleep and infant care were provided to the parents by the hospital at the time of

the SC birth, however the materials were in English which the family does not speak. Educational materials regarding safe sleep should be available to families in their native language or interpreter assistance should be utilized in reviewing the information with them.