Report Identification Number: RO-17-020

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

Issue Date: Oct 18, 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 **Jurisdiction:** Steuben **Date of Death:** 06/12/2017
Age: 1 month(s) **Gender:** Male **Initial Date OCFS Notified:** 06/13/2017

Presenting Information

An SCR report was received on 6/13/17 regarding the death of the 1-month-old SC. The report alleged on 6/12/17 the SM woke up around 8:30AM to burp the SC. The SM fell asleep with the SC on her lap and when she awoke around 10:50AM he was unresponsive and had blood around his nose and mouth. The SC was also observed with an unknown material coming from his nostril. When the SM saw that the SC was not moving she called the SF who was in another room. The SF and SM attempted CPR before calling 911 at 10:55AM. The SM's explanation was inconsistent as she initially reported placing the SC upright on a pillow, on the couch next to her before she fell asleep.

Executive Summary

This fatality report concerns the death of the 1-month-old male SC that occurred on 6/12/17. The fatality was reported to the SCR on 6/13/17. The report alleged DOA/Fatality and IG against the SM and SF regarding the SC. The SM fell asleep on the couch while holding the SC and awoke to him lying face down in her lap. The SF was sleeping in a bedroom. Steuben County Department of Social Services (SCDSS) and LE jointly investigated the death of the SC. The SC was the only child of both the SM and SF. The SC was an otherwise healthy child with no medical issues.

SCDSS interviewed both the SM and SF on multiple occasions after the fatal incident. The SF had woken several times during the evening of 6/11/17 and the early morning of 6/12/17 to care for the SC, while the SM slept. The SM and SF were sleeping on an L-shaped sofa in the living room with the SC positioned in the middle of them. That was the normal sleeping arrangement for the SM, SF and SC. The SF woke the SM up to feed the SC the morning of 6/12/17 and the SF then went into a bedroom to sleep. The SF heard the SC crying 5 minutes later and went into the living room to find the SM had fallen asleep while holding the SC. The SF woke the SM again and she began feeding the SC. The SF went back into the bedroom to sleep. Several hours later the SM woke up and found the SC lying face down in her lap. The SM yelled for the SF because the SC was not breathing and had blood coming from his nose. The SF came into the room and 911 was called. Despite rescue efforts of the SM, SF, LE and EMS, the SC could not be saved.

The ME completed an autopsy of the SC. The cause and manner of death were undetermined, pending the toxicology results at the time this report was written. SCDSS made contact with the ME on several occasions and requested the preliminary autopsy report. The ME had not provided this information at the time this report was written.

LE found a large amount of cash and pain medication in the home. Neither the SM or SF had a prescription for the medication and LE confiscated it for their criminal investigation. LE also took the SM and SF's cell phones. LE had the information from the phones searched in an effort to determine if there was criminal activity occurring in the home around the time of the fatality. LE found the SM was regularly selling drugs and the SF was aware of both the SM's sale and use of the drugs. LE charged the SM with criminal possession of a controlled substance in the 3rd degree. SCDSS asked both the SM and SF to take drug tests. The SF admitted to illicit drug use before and after the death of the SC, but the SM denied any drug use before the fatality. They both denied they were using drugs in the time leading up to the fatality. There was some suspicion by collaterals contacted that the SM was using drugs and may have been impaired at the time of the SC's death. The SM later told LE that she had taken pain medication not prescribed to her on the evening of 6/11/17, but did not think it would impact her behavior, because she regularly used this drug.

SCDSS spoke with family members and friends of the SM and SF during their investigation and documented information they received regarding the relationship between the SM and SF and their care for the SC. SCDSS made several home

visits and also met with the SM and SF at the agency. SCDSS also spoke with first responders, the pediatrician, the hospital and MH providers. SCDSS also reviewed records from medical providers and LE. SCDSS offered the SM and SF assistance in paying for the burial of the SC but they declined. SCDSS referred the SM and SF for grief counseling and MH services. Additionally, SCDSS referred the SM and SF for a substance abuse evaluation; the SF declined the referral.

SCDSS appropriately substantiated the allegations of IG, DOA/Fatality and PD/AM against the SM and SF. SCDSS found credible evidence the SM was impaired at the time of the SC's death and the SF was aware.

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:
SCDSS conducted a thorough investigation and gathered enough information to make the determination.

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: 06/12/2017 **Time of Death:** 12:05 PM

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

County where fatality incident occurred: Steuben

Was 911 or local emergency number called? Yes
Time of Call: 10:55 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:

- [x] 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:

- [x] Drug Impaired
- [ ] Absent
- [ ] Alcohol Impaired
- [x] 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	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

After receiving an SCR report on 6/13/17, SCDSS commenced their investigation regarding the death of the SC. SCDSS contacted the source, LE, ME, EMS, the coroner, medical providers and family members of the SC during their investigation. SCDSS also checked CPS and criminal history for both the SM and SF. SCDSS learned the SC was found deceased on the morning of 6/12/17. The SM and SF were both home at the time. The SC had no siblings and was an otherwise healthy child.

SCDSS investigated the death of the SC in conjunction with LE. Initially the SM told LE she awoke and found the SC sitting in a "Boppy" pillow on the sofa with blood coming from his nose. A short while later, the SM reported she awoke and found the SC face down in her lap with blood coming from his nose. SCDSS also interviewed the SM separately from LE. The SM told SCDSS the evening of 6/11/17 the SF, SC and herself all went to sleep on the L-shaped sofa. The SM reported the family always slept together on the sofa, the SM on one side, the SF on the other, and the SC sitting up in the Boppy pillow in the middle. The SM and SF awoke to the SC crying the morning of 6/12/17 and the SF prepared a bottle and gave it to the SM to feed the SC. The SM reported feeding the SC and then putting him over her shoulder to burp him. The SM said the SC fell asleep like this and she must have fallen asleep as well. The SM awoke to the SC lying face down in her lap with a drop of blood coming from his nose. The SM had no idea what time these events occurred. The SM repeatedly apologized for the death of the SC.

The SF told SCDSS he and the SM had been arguing most of the day on 6/11/17. The SF said the SM had to go to the ER because she cut her foot on glass, and when they returned home he cared for the SC all day until they all went to sleep at 11:00PM. The SF also reported the SM, SC and himself regularly slept on the couch, as they did that night. The SF awoke to feed the SC three times during the night. The SF woke to the SC crying the third time at 7:30AM. The SF was exhausted and tried to play with the SC before he finally prepared a bottle and woke the SM to feed the SC. The SM took the SC and bottle and the SF went into the bedroom to sleep. The SF heard the SC screaming 5 minutes later and returned to the living room. The SF found the SM holding the SC and she had fallen asleep. The SF woke the SM and directed her to feed the SC, and an argument ensued. After several minutes, the SM did begin to feed the SC and the SF returned to the bedroom. The SF woke a few hours later to the SM screaming for him. The SF went into the living room and found the SM lying on her stomach on the floor and the SC lying on his back on the couch. The SF reported he picked up the SC and he had blood coming from his nose and was limp. The SF told the SM to call 911 and he began CPR on the SC. When the 911 operator answered, the SF took the phone and began to talk to the operator and the SM resumed CPR.

First responding LE told SCDSS when they arrived to the home the SM was giving the SC CPR while the SF was on the phone with a 911 operator. LE attempted to connect the SC to an Automated External Defibrillator, but the machine could not find a pulse. EMS arrived and connected the SC to a cardiac monitor, confirming he was deceased. LE and EMS reported the SC had blood coming from his nose. EMS stated the coroner was then called to the home. The coroner arrived at the home and declared the SC deceased. The SC was then taken to the ME for an autopsy.

Both the SM and SF denied any alcohol or drug use leading up to the fatality. SCDSS drug tested the SM and SF 2 days after learning about the fatality and both tested positive for illicit drugs. The SM and SF reported they occasionally used drugs before and after the death of the SC. The parents had a bassinet for the SC but reported he always slept with them on the sofa. The SM and SF had received information about safe sleep.

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)?No

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039161 - Deceased Child, Male, 1 Mons	039163 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
039161 - Deceased Child, Male, 1 Mons	039162 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
039161 - Deceased Child, Male, 1 Mons	039163 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
039161 - Deceased Child, Male, 1 Mons	039163 - Father, Male, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated

039161 - Deceased Child, Male, 1 Mons	039162 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
039161 - Deceased Child, Male, 1 Mons	039162 - Mother, Female, 22 Year(s)	Parents Drug / Alcohol Misuse	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
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 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	☐	☐	☐	☐	☐	☒	☐

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.

Known CPS History Outside of NYS

There is no known CPS History outside of New York State.

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