Child Fatality Report

Report Identification Number: AL-17-019

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

Issue Date: Nov 27, 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	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: 4 month(s)
Jurisdiction: Albany
Gender: Female
Date of Death: 06/18/2017
Initial Date OCFS Notified: 06/18/2017

Presenting Information

On 6/18/2017 the SCR received a report alleging that at approximately 11:15 AM, the SM was sleeping on the couch with SC 4-months-old. The SM was on the couch with the SC and rolled over on the SC while they were sleeping. Thus, the SC was found with vomit on her face and not breathing. The SC was an otherwise healthy baby. The SC was pronounced dead at 11:44 AM with an unknown cause of death. Roles of the BF, MGA, another family member, MA (age 15) and the MGF were all listed with no role.

Executive Summary

On 6/18/2017, Albany County Department of Children, Youth and Families (ACDCYF) received two reports about the death of the SC from the SCR with the same allegations of DOA/Fatality and IG for the SC against the SM. There were no SS. The other child listed in the household was the 15-year-old Aunt (MA) of the SC and the SM's sibling. It was alleged that the SM was asleep on the couch with the SC. The SM had placed the SC on her back behind her on the couch. The Maternal Great Aunt (MGA) went to wake up the SM and the found the SC face up with blood and milk on her face. The SM woke up saw the SC and ran out of the home screaming. The MGA began CPR and another adult that was in the home at the time called 911. EMS arrived and transported the SC to hospital, where the SC was pronounced dead.

A joint investigation was conducted by ACDCYF and LE. ACDCYF initiated an immediate investigation which included contact with the source and all other required contacts. SCR and criminal history checks were completed and reviewed. The SM had a no known history of drug/alcohol misuse. There were no SS. Everyone who was present the day of the incident was interviewed and the home environment was observed. There were no safety concerns noted. The BF was interviewed. The other child listed in the home at the time of the reported incident was the 15-year-old MA. ACDCYF offered bereavement referrals and assistance with burial expenses.

ACDCYF conducted a 24-hour safety assessment and determined there were no SS. The 15-year-old MA of the SC was only visiting with the MGA and resided with her father, the MGF of the SC. There were no safety concerns for the 15-year-old MA.

The autopsy results were still pending at the time of the writing of this report. Law Enforcement reported the preliminary autopsy results there no injuries to the child and no known medical explanation for the death. Law Enforcement also reported the death was found to be unremarkable and probably the result of infant co-sleeping with the parent. The Pediatrician's office and mother confirmed that there were no known medical issues for the child. There was no evidence of a criminal act. No arrests were made.

ACDCYF Sub the allegations of DOA/Fatality and IG for the SC against the SM. The SM admitted to and by all other accounts from family members present the day of the reported fatality; the SM had been co-sleeping with the SC. The SM had a bassinet for the SC but did not bring it to the MGA's home, where she had been staying for several weeks. The SM admitted to sleeping on the couch and having the SC placed between her and the back of the couch to go to sleep. The SM failed to provide minimum degree of care for the SC by placing her in an unsafe sleep environment, where she subsequently died. The case was IND and closed no further services needed. There were no SS.

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?** Yes

Explain:
OCFS found that ACDCYF made the appropriate determination based on the information gathered during the investigation.

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:
ACDCYF there were no SS and the SM refused the services that were offered.

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: 06/18/2017 **Time of Death:** 11:44 AM

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

County where fatality incident occurred: Albany

Was 911 or local emergency number called? Yes
Time of Call: 11:12 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
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	Aunt/Uncle	No Role	Female	16 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	31 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Other Adult - other family member	No Role	Male	33 Year(s)
Other Household 1	Grandparent	No Role	Male	59 Year(s)
Other Household 2	Father	No Role	Male	21 Year(s)

LDSS Response

On 6/18/2017, ACDCYF received an SCR report alleging DOA/Fatality, and IG against the SM for the 4-month-old SC. Through interviews and information gathered from LE and collateral, it was reported that on the evening of 6/17/2017 the MGA was at the home with the SC, the 15-year-old MA of the SC and another family member. The SM was out that evening. The MGA reported to ACDCYF that she had been caring for the SC that evening and had kept the SC up until midnight. The MGA demonstrated that she had placed the SC on the sectional couch to sleep between to pillows with the top of her head facing the back of the couch and her feet at the edge of the couch. The SC was placed vertical on the couch, the same position you would be in if sitting. The 15-year-old MA was sleeping on the other section of the sectional. The MGA said she woke up between 4 and 5 am to go to the bathroom. She checked on the SC and the SC was in the same position she had placed her in and was sleeping. The MGA went back to bed and got up at 9 AM, she came out and the SM was home and asleep on the sectional. The baby was on her back behind the SM. The SM was sleeping on her side with her face and body facing away from the SC. The SC was on her back sleeping and was not observed to have anything on her face and was sleeping. The MGA said she wanted to let them sleep because she knew the SM had not arrived home until sometime after 5 AM. The MGA said she went into the kitchen at 10 AM and made breakfast for everyone when she came out of the kitchen to wake everyone she found the SC with blood and vomit on her face. The MGA began CPR and the SM woke screaming and ran outside. The other family member called 911 at 11:12 AM. The SM reported she had been out with friends and was not drinking. She arrived at the home early in the morning on 6/18/2017 and fed the SC at 7 AM.

She then placed the SC between her body and the back of the couch. She went to sleep and woke up to her MGA taking the SC and performing CPR. She screamed and ran outside. EMS arrived and transported the SC to the hospital and the SC died at 11:44 AM. When ACDFY talked with the SM, she explained she had been living with her sister prior to staying with the MGA and had a bassinet for the SC at her sister's home. When asked why she had not taken the bassinet to the MGA home for the SC, she did not answer the worker. ACDCYF interviewed the sister who confirmed she had been living with her and had left the home but did not take the bassinet with her. The sister said the SM never co-slept with the SC while in her home.

ACDCYF conducted a 24-safety assessment to determined if there were SS or other chn in the home. There were no SS. ACDCYF interviewed the 15-year-old MA the other child listed in the home at the time of the incident. ACDCYF learned that 15-year-old MA had been visiting the MGA but resides with her father, the SC's MGF.

All appropriate collateral contacts were made and an SCR history, criminal and WMS system checks were completed and reviewed. All family members were interviewed and the home environments were observed and deemed safe. All family members stated they had no concerns for the care the SM provided the SC.

The ACDCYF made home visits during the investigation and offered referrals for grief counseling to the SM and the BF. ACDCYF spoke with the MGA, who was pregnant at the time of the INV, about safe sleep practices. ACDCYF gathered information from LE, medical professionals and the SC's pediatrician. There were no reported concerns regarding the care of the SC. The preliminary medical findings regarding the SC's death, were that SC's death was unremarkable and there were no injuries. The autopsy results were still pending at the time of the writing of this report.

ACDCYF Sub the allegations of DOA/Fatality and IG for the SC against the SM. The size of the sleeping surface in relation to the occupants created an unsafe condition, thereby placing the SC in immediate danger.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Coroner

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041769 - Deceased Child, Female, 4 Mons	041770 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Substantiated
041769 - Deceased Child, Female, 4 Mons	041770 - Mother, Female, 18 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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?	☐	☐	☒	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

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:
There were no SS, the other chn listed in the home was the 15 year-old Aunt to the SC and the sibling of the SM.

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 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:
ACDCYF did offer to provide the SM with services if needed. SM refused assistance from ACDCYF.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACDCYF referred parents for bereavement counseling.

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 was no history regarding the alleged subject in the report as perpetrator.

Known CPS History Outside of NYS

There is no known history outside of NYS.

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