NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SY-16-026 **Prepared by: Syracuse Regional Office**

Issue Date: 12/5/2016

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
FM-Foster Mother	SS-Surviving Sibling	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 06/06/2016
Initial Date OCFS Notified: 06/06/2016

Presenting Information

Sometime before 8:00AM this morning (6/6/16), the BF took the four-month-old SC and 7-year-old half-sibling from the BM who went to work. The BF dropped the 7-year-old half-sibling off at his babysitter and the BF returned home. The BF left the SC in the vehicle in his car seat and went inside where he fell asleep. The BF woke up 7-8 hours later and found the SC was still in the vehicle and was not breathing. The BF attempted to revive the SC and called 911. The SC was pronounced dead shortly after. The role of the BM, half-sibling and half-sibling's mother are unknown.

Miscellaneous Information:
The BF works overnights as a police officer and usually sleeps during the day. EMS received the call at 4:25PM. The SC was pronounced dead at 5:04PM. The SC's body temperature was 104.6. Cause of death is believed to be heat stroke. The Oneida County Sherriff's Department is investigating.

Executive Summary

The report involved the death of a four-month-old male child. The SC was pronounced dead on 6/6/16 at 5:04PM. A report was registered with the SCR on 6/6/16 with allegations of IG, Lack of Supervision and DOA/Fatality against the BF regarding the SC after the SC was found unresponsive by the BF after being left unattended while secured in a car seat in a closed parked vehicle for approximately eight hours. The investigation determined that on the morning of 6/6/16 the BF placed the SC and the 7-year-old half-sibling in his vehicle. The BF dropped the sibling off at daycare and returned home without dropping the SC off at his daycare provider. The BF exited the vehicle and entered the home, where he cleaned the carpet and took a nap, while the SC remained in the vehicle parked in the driveway. The BM was at work at the time of the incident. The household consisted of the BM, BF, SC and a 7-year-old half-sibling who visited the home weekly.

The Final Autopsy Report listed the Cause of Death as Hyperthermia due to confinement within parked vehicle and Manner of Death as Accident. The medical examiner commented "Based on consideration of circumstances surrounding the death, review of available medical history/records, autopsy examination, and toxicological analysis, the death of the SC, to a reasonable degree of medical certainty, is ascribed to hyperthermia due to confinement within parked automobile. Based on the circumstances surrounding the death, as currently known, the manner of death is accident."

Oneida County DSS (OCDSS) obtained medical records, the preliminary and final autopsy, law enforcement records, and made all appropriate collateral contacts. Safety of the surviving sibling was appropriately assessed.

On 10/4/16, OCDSS completed their investigation and substantiated the allegations of IG, Lack of Supervision and DOA/Fatality against the BF regarding the SC. It was determined that there was credible evidence that the BF failed to exercise a minimum degree of care and supervision when he left the SC unattended and confined in a vehicle for eight hours, and that failure directly resulted in the SC's death. The BF was the sole caregiver of the SC when he left him alone in a vehicle, resulting in the SC's death by hyperthermia due to confinement within parked automobile.

Oneida County Sherriff's Department investigated the death of the SC and the case was reviewed by the District Attorney's office. No charges were filed against the BF.

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:
The LDSS gathered appropriate information to determine the allegations in the report. All casework activity was commensurate with 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:
The LDSS gathered appropriate information to determine the allegations in the report. All casework activity was commensurate with case circumstances.

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: 06/06/2016 **Time of Death:** 05:04 PM

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

County where fatality incident occurred: ONEIDA
Was 911 or local emergency number called? Yes
Time of Call: 04:25 PM
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? No - but needed
At time of incident supervisor was: Unknown if they were 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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	No Role	Female	31 Year(s)
Other Household 1	Other Adult	No Role	Female	34 Year(s)
Other Household 1	Sibling	No Role	Male	7 Year(s)

LDSS Response

The LDSS investigation revealed that the four-month-old SC resided with the BM, BF and a 7-year-old half-sibling who visited the home on a regular basis. The sibling's primarily residence was with his mother and step-father.

It was determined that on 6/6/16 at about 6:05AM, the BM fed and changed the SC. The BM left for work at approximately 6:40AM, leaving the SC, and the 7-year-old sibling who had spent the night at the home, in the care of the BF. The BF had the day off from work and planned to bring the SC and sibling to their respective daycare providers. The BF typically brought the sibling to his daycare provider when he would spend the night with the BF. The BM typically brought the SC, who had only been in daycare for 3-weeks prior to this incident, to his daycare provider; however the BF had brought the SC on three occasions when he also had the sibling with him. At approximately 8:00AM on the morning of 6/6/16 the BF placed the SC and sibling in the car and transported the sibling to his daycare provider. The BF removed the SC in his car seat and entered the daycare center to drop off the sibling. The BF returned the SC, who was sleeping in his car seat at the time, to the passenger side back seat of the vehicle. The BF began listening to talk radio and proceeded to drive home, forgetting to bring the SC to his daycare provider. When the BF returned home he exited the vehicle and

entered the home, where he cleaned the carpet; spoke to the BM on the telephone; paid the daycare fees for the SC using an application on his telephone; drank a small amount of "Jack Daniels"; and took a nap, while the SC remained in the vehicle parked in the driveway. At approximately 4:10PM the BM called and woke the BF and told him that she was picking up the SC. A short time later, the BM called the BF again when she learned that the SC was not at the daycare provider and asked where he was. At that time, the BF realized that the SC was still in the vehicle and ran outside to get the SC out of the vehicle. A neighbor heard the BF distraught and called 911 while the BF removed the SC from the car seat and began CPR. When EMS arrived, they took over resuscitation efforts and transported the SC to the hospital where he was pronounced dead at 5:04PM. The SC was found to be Asystole with modeling and rigor set in and had a body temperature of 104.6 degrees. The BF stated that he forgot that the SC was in the vehicle. Law enforcement responded to the scene and conducted an investigation. A blood test was administered to the BF following the SC's death due to the BF's admission to consuming alcohol prior to taking a nap and found that the BF had no alcohol in his system.

The Final Autopsy Report listed the Cause of Death as Hyperthermia due to confinement within parked vehicle and Manner of Death as Accident. LDSS responded appropriately to the death by interviewing parties involved, obtaining and reviewing medical and law enforcement records, gathering information from first responders, making collateral contacts, and offering appropriate services, including assistance with burial and counseling services.

On 10/4/16, OCDSS completed their investigation and substantiated the allegations of IG, Lack of Supervision and DOA/Fatality against the BF regarding the SC. It was determined that there was credible evidence that the BF failed to exercise a minimum degree of care and supervision when he left the SC unattended and confined in a vehicle for eight hours, and that failure directly resulted in the SC's death. The BF was the sole caregiver of the SC when he left him alone in a vehicle, resulting in the SC's death by hyperthermia.

The LDSS gathered appropriate information to determine the allegations in the report. Counseling information was provided to the parents; however they sought their own services. All casework activity was commensurate with case circumstances.

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

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
032141 - Deceased Child, Male, 4 Mons	032143 - Father, Male, 34 Year(s)	Lack of Supervision	Substantiated

032141 - Deceased Child, Male, 4 Mons	032143 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
032141 - Deceased Child, Male, 4 Mons	032143 - Father, Male, 34 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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Explain as necessary:
The surviving sibling did not reside in the household; however had regular weekly overnight visits in the home. The safety factor identified was 'Parent/Caretaker is unable and/or unwilling to provide adequate supervision of the child(ren)'. Safety interventions in place were law enforcement investigation and the surviving child resided in a separate household with his BM.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
OCDSS provided bereavement counseling information and offered burial assistance to the parents. The parents attended a monthly support group and the BM obtained counseling services on her own.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were provided with bereavement counseling information and offered assistance with burial arrangements.

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 NYS

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