Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-17-030

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

Issue Date: Dec 11, 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: 9 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 08/13/2017
Initial Date OCFS Notified: 08/14/2017

Presenting Information

The morning of 8/13/2017, at 11:30 AM, the 9-month-old SC was found unresponsive after sleeping in the bed with the SM, and the SC subsequently died. The MGM, MA and BF had unknown roles. The SM called 911 and EMS transported the SC to the hospital where the SC was pronounced dead. The SC reported the SC last awoke at 6:30 AM. The SC was born premature and only weighed one pound at birth. The SC had a feeding tube. The SC kept waking up the night before and had trouble keeping food down. The SM reported that she had called the SC's doctor. The cause of death was unknown.

Executive Summary

An SCR report was received on 8/13/2017, regarding the death of the 9-month-old SC. Monroe County Department of Human Services (MCDHS) initiated an immediate investigation that included contact with the source and all other required contacts. SCR and criminal history checks were completed and reviewed, it was learned that SM, MGGM and BM had no previous history with CPS. There was no known history of drug or alcohol misuse by the SM or the BF. It was learned in the first 24 hours of the INV that, the SC was a medically fragile child, who was born with multiple medical issues. The SC was born premature at 25 weeks' gestation and had remained in the NICU for the first 7 months of life. The SC was sent home on 5/17/2017. The SM reported the SC had numerous medical appointments and did provide LE and MCDHS with a binder that she kept on all the SC's appointments and on going care. The SM fully cooperated with LE and MCDHS and signed all necessary releases. All family members present in the home were interviewed and their accounts of the events that led up to the SC being found unresponsive on the morning of 8/13/2017 were consistent. The SM reported the SC had not been feeling well the night before and the SM had called the doctor. This was confirmed by the doctor. The last time the SM fed the SC was at 6:30 AM. The SM had placed the SC on a pallet made for her on the bed and went back to sleep. The pallet was made from two firm couch cushions with a crib sheet placed over them. This was what the SC normally slept on but not on the SM's bed. She had placed it on the bed because the SC hadn't been feeling well and the SM wanted her close to her. When the SM awoke at 11:30 AM the SC was unresponsive and her stomach was distended. There was fluid coming out of the gastrostomy and jejunostomy tubes. The SC had to have food and medications administered through the tubes. 911 was called and EMS arrived and transported the SC to the hospital. The SC was pronounced dead at 12:03 PM.

MCDHS determined in the first 24 hours there were no SS and no other chn in the household. MCDHS made a home visit and spoke with all family members, observed the home and there were no noted safety concerns. MCDSS offered the family referrals for bereavement and assistance with burial costs.

MCDHS received the preliminary findings from the ME. The manner and cause of death were still pending at the time of the writing of this report. MCDSS spoke with the SC's medical providers and obtained the SC's medical records and reviewed them. The SC death was not a suspicious death and it was believed that the SC died as result of the SC's multiple medical issues.

MCDHS appropriately Unsub the allegations of DOA/Fatality and IG against the SM for the SC. Through interviews and medical documentation, the SC was a medically fragile child. There was no evidence to support that the SC sleep environment was the cause of the SC's death. The case was unfounded and closed. The family was receiving community based services. 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:**
  - **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:
MCDHS gathered sufficient information to make a determination. There were no SS or other children living in the household.

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:
There were no SS. MCDHS offered assistance and referrals for bereavement counseling for the family.

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: 08/13/2017 **Time of Death:** 12:03 PM

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 11:30 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:

- [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:

- [ ] Drug Impaired
- [ ] Alcohol Impaired
- [ ] Distracted
- [ ] Impaired by disability
- [ ] Absent
- [x] 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	Aunt/Uncle	No Role	Female	19 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	9 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Other Household 1	Father	No Role	Male	26 Year(s)

LDSS Response

On 8/13/17, MCDHS received an SCR report alleging DOA/Fatality and IG against SM for the 9-month-old SC. MCDSS began an immediate INV, during the investigation MCDHS interviewed the source and interviewed all first responders. The SM, MGGM and BF were interviewed and observed. All appropriate collateral contacts were made including, pediatrician, medical specialists, home care provider, the ME and family members. There were no reported concerns of the SC's care from any of the medical providers. SCR history check was completed and reviewed. Criminal history check was completed. There was no evidence of drug or alcohol misuse.

MCDHS determined there were no SS and no other chn in the household. SM and MGGM provided a timeline for MCDHS regarding the events leading up to the SC death. The SM and the MGGM statements to both LE and MCDHS were consistent. The BF was interviewed and had no concerns regarding the SM's care of the SC.

The SM told MCDHS that the SC was born premature and only weighed one pound at birth. The SC had multiple medical issues. The SC remained in the hospital for 7 months after being born. The SC was discharged home on 5/17/2017 with in home care provided. The SC had a gastrostomy-jejunostomy tube to administer daily medication and feeding. On 8/12/2017, the family that the SC was not feeling well and the SC had loose bowls and was more fussy than usual. The SM called the NICU and they had the SC's pediatrician call the SM back. After updating and consulting with the pediatrician the SM gave the SC a dose of ibuprofen as instructed. MCDHS confirmed this conversation with the SC's pediatrician. Later that same evening the SC was still fussy and the SM had laid the SC face up on a pallet that she had made for the SC.

The pallet consisted of two firm couch cushions with a crib sheet placed over the top. The SM had placed the pallet on her bed because the SC was not feeling well. At 6:30 AM the SM awoke and fed the SC through the feeding tube and they went back to sleep. At 11:30 AM the SM awoke and found the SC unresponsive with fluid coming from both tubes. 911 was called and EMS arrived and took the SC to the hospital where the SC was pronounced dead. The SM showed LE the SC's binder with all the medical information she kept on hand for the SC. The SM signed all necessary releases for of the SC's care providers.

MCDHS obtained and reviewed all the medical records and spoke the appropriate providers. The SC's medical providers stated the SM provided appropriate care for the SC and they had no concerns. It was believed in speaking with all the medical providers that the SC passed away because of the multiple medical issues. An autopsy was done and the manner and cause of death were still pending at the time of the writing of this report. The ME reported there no injuries or signs of abuse/maltreatment of the SC. No arrests were made.

The allegations of DOA/fatality and IG regarding the SC by the SM were Unsub. The SC was a medically fragile child and there was no evidence that the SC's sleep environment caused the SC's death. There were no SS and the case was closed and the family was referred to community based services.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
042423 - Deceased Child, Female, 9 Mons	042424 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
042423 - Deceased Child, Female, 9 Mons	042424 - Mother, Female, 25 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

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 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:
There were no SS. However, MCDHS did offered services and assistance to 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 were no SS or other children listed in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDSS offered bereavement referrals and burial assistance.

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? Yes

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.

Known CPS History Outside of NYS

There is no known history outside the state of NY.

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