Child Fatality Report

Report Identification Number: RO-19-035

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

Issue Date: Mar 05, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 11 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 10/13/2019
Initial Date OCFS Notified: 10/13/2019

Presenting Information

An SCR report received on 10/13/19 alleged that while in the care of the mother, grandmother and sibling, the 11-year-old subject child died. The subject child was last seen alive on 10/13/19 at approximately 5:00 AM. At 12:40 PM, the mother checked on the subject child and found her unresponsive. EMS performed CPR while transporting the subject child to the hospital. The subject child was pronounced deceased at 1:48 PM.

Executive Summary

This report concerns the death of the 11-year-old subject child. Monroe County Department of Human Services (MCDHS) received an SCR report on 10/13/19, regarding the child's death on the same date. The subject child had been ill the days leading up to her death.

On 10/11/19, the subject child had not been feeling well and was taken to the pediatrician. The pediatrician had run some tests and the subject child's blood pressure was high as well as her pulse. The pediatrician found ketones in her urine and she was showing signs of dehydration. The pediatrician sent the subject child to the emergency room where she was treated and released sometime after midnight. The subject child slept most of that day (10/12/19) and still complained of her head hurting. Sometime after 11:00 PM (10/12/19) the mother went to a store to purchase over the counter medication. At 12:00 AM and 5:00AM on 10/13/19, the mother gave the subject child the over the counter medication. At 12:00 PM the mother went to check on the subject child as she had been sleeping for a long time and the subject child was unresponsive. 911 was called and EMS arrived and transported the subject child to the hospital where she was pronounced deceased at 1:48 PM.

The medical examiner was notified, and an autopsy was completed; the final autopsy report was pending at the time of this writing. Based on a review of the medical records, interviews with family members and medical professionals, it was believed the subject child died from a medical cause. Law enforcement had not made any arrests and their investigation remained open, pending the final autopsy.

MCDHS determined there were two adult surviving siblings residing in the home and an 18-month-old niece. MCDHS assessed the safety of the 18-month-old and there were no noted safety concerns.

MCDHS completed required reports timely and accurately. MCDHS continued to gather information, made follow up visits and offered appropriate services to all family members. The mother was struggling with the death of the subject child, and her mental health declined to the point where she had suicidal ideations. MCDHS involved mobile crisis and assisted the family with the appropriate services needed to support the mother.

MCDHS unsubstantiated the allegations of DOA/fatality, inadequate guardianship and lacerations/bruises/welts against the mother, the grandmother and the 22-year-old adult sibling for the subject child. Based on medical information and family members interviews, it was learned the subject child had been seriously ill in August of 2019 and had been hospitalized for over a month. She had multiple medical concerns such as her kidney function, dehydration and high blood pressure. The subject child was getting better but had still been experiencing severe headaches. There were no bruises observed on the subject child, but there was a rash observed on her face and neck. The subject child had been to the doctor and the emergency room on 10/11/19. The hospital treated and released her. The subject child died on 10/13/19, and it was believed to be from a medical cause. There was no credible evidence that the actions or inaction of the alleged subjects

contributed to the child's death. The case was unfounded and closed. MCDHS provided the family with multiple referrals for community-based services.

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:
Prior to closing their investigation, MCDHS connected the family with appropriate services to meet the family's needs.

Was the decision to close the case appropriate? N/A

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:
MCDHS gathered sufficient information to make a determination in the case.

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: 10/13/2019 **Time of Death:** 01:48 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: Unknown
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
How long before incident was the child last seen by caretaker? 7 Hours
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	Deceased Child	Alleged Victim	Female	11 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	67 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	45 Year(s)
Deceased Child's Household	Other Child - niece	No Role	Female	18 Month(s)
Deceased Child's Household	Sibling	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Sibling	No Role	Female	22 Year(s)
Other Household 1	Father	No Role	Male	44 Year(s)
Other Household 2	Father	No Role	Male	23 Year(s)

LDSS Response

On 10/13/19, MCDHS received the fatality report from the SCR, initiated their investigation within 24 hours and coordinated efforts with law enforcement. MCDHS contacted the source of the report, completed a CPS history check, and notified the medical examiner and the district attorney. There were no surviving minor siblings; however, the 22-year-old adult sibling lived in the home with his 18-month-old daughter. MCDHS assessed the safety of the 18-month-old child, and there were no noted concerns.

MCDHS interviewed the mother, the grandmother and the two adult siblings about the events leading up to the subject child's death on 10/13/19 and their statements were consistent. The grandmother and the mother said that on Friday 10/11/19, the subject child was not feeling well, and they had taken her to her pediatrician who conducted some tests and found the subject child's blood pressure was high as well as her pulse. The pediatrician found ketones in her urine which were indicative of dehydration, and sent the subject child to the emergency room. The emergency room put her on IV

fluids and gave her a medication to help with the headache. The grandmother and the mother said the hospital released the subject child at 12:00 AM on 10/12/19. Both said the subject child went home and went to bed with a cold compress on her forehead. The subject child slept on and off all day on 10/12/19. The subject child said her head still hurt. The mother said at 11:30 PM she went to purchase over the counter medication. Sometime around 12:00 AM the mother said she gave the subject child the medication. The mother said at 5:00 AM the subject child banged on her wall to get her attention and she gave her more medication. The grandmother said she woke at 5:30 AM to take the 22-year-old adult sibling to work and when she arrived home, she checked on the subject child and she was sleeping. The grandmother said she went back to bed and later woke to take a shower. While in the shower she heard the mother screaming for her to call 911. The mother said she went to check on the subject child and found her sprawled across her bed on her back and she was unresponsive. The grandmother said she called 911 and the subject child was transported to the hospital.

The adults in the home told MCDHS about the subject child's health since August of 2019 and how she had spent over a month in the hospital. The subject child underwent numerous tests to determine what was making her sick. The tests showed damage to a kidney, which was believed to have been caused from the dehydration the subject child had upon admission to the hospital. The subject child had high blood pressure as well. The subject child was treated and released home from the hospital and was doing well. The medical records obtained supported the family members' statements.

The MCDHS obtained information from law enforcement, the medical examiner, medical staff and medical records from the hospital, and the subject child's and the niece's pediatrician. MCDHS appropriately added, notified and interviewed the father of the niece and he had no concerns for the care his child. MCDHS added the father of the subject child to the report and made efforts to locate and speak with him but were not successful. MCDHS offered family members referrals for bereavement services and additional services for the mother. The mother showed a significant decline in her mental health during the investigation as she was struggling with the death of the subject child. The mother had suicidal ideations and was misusing drugs and alcohol. MCDHS had arranged for Mobile Crisis to come an evaluate the mother at the home. The mother's mental health decline continued, and she was hospitalized at the time of the investigation determination. MCDHS met with family members and provided them with a multitude of community-based services which the family accepted.

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
051741 - Deceased Child, Female, 11 Yrs	051742 - Mother, Female, 45 Year(s)	DOA / Fatality	Unsubstantiated
051741 - Deceased Child, Female, 11 Yrs	051742 - Mother, Female, 45 Year(s)	Inadequate Guardianship	Unsubstantiated

051741 - Deceased Child, Female, 11 Yrs	051742 - Mother, Female, 45 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
051741 - Deceased Child, Female, 11 Yrs	051743 - Grandparent, Female, 67 Year(s)	DOA / Fatality	Unsubstantiated
051741 - Deceased Child, Female, 11 Yrs	051743 - Grandparent, Female, 67 Year(s)	Inadequate Guardianship	Unsubstantiated
051741 - Deceased Child, Female, 11 Yrs	051743 - Grandparent, Female, 67 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
051741 - Deceased Child, Female, 11 Yrs	051745 - Sibling, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
051741 - Deceased Child, Female, 11 Yrs	051745 - Sibling, Female, 19 Year(s)	Inadequate Guardianship	Unsubstantiated
051741 - Deceased Child, Female, 11 Yrs	051745 - Sibling, Female, 19 Year(s)	Lacerations / Bruises / Welts	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?	☒	☐	☐	☐
Was there an adequate 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	☒	☐	☐	☐

Explain:
MCDHS offered and provided multiple community-based services for the family to meet their needs.

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 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 surviving minor siblings; however, the 18-month-old child who resided in the home remained with her mother. MCDHS assessed the safety of the niece and there were no noted safety concerns. A safety plan was made with the niece's mother (the 22yo adult sibling) and the grandmother, not to leave the niece alone with the mother of the subject child due to her suicidal ideations and her misuse of drugs/alcohol since the death of the subject child.

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	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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
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

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 were three previous reports dated 2008, 2014 and 2015. The 2014 and 2015 reports were tracked FAR. The FAR reports had allegations of inadequate guardianship, educational neglect and parents drug/alcohol misuse. The allegation for the 2008 report was inadequate guardianship and was unsubstantiated against the mother for children.

Known CPS History Outside of NYS

There was no known history outside of NYS.

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