Child Fatality Report

Report Identification Number: RO-17-045

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

Issue Date: Jun 07, 2018

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 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 12/09/2017
Initial Date OCFS Notified: 12/10/2017

Presenting Information

An SCR report was received which alleged the 4-year-old subject child was at a party with her mother when she began to feel ill and laid down. When the mother went to check on the subject child, she found her unresponsive. The mother called 911 and the subject child was pronounced deceased at the scene. The subject child was otherwise healthy, and her cause of death was unknown. The role of the child's father was unknown.

Executive Summary

This fatality report concerns the death of a 4-year-old female subject child (SC) that occurred on 12/9/17. A report was made to the SCR on 12/10/17, with allegations of IG and DOA/Fatality against the subject child's mother (SM). The fatality investigation was conducted by Monroe County Department of Human Services (MCDHS). The final autopsy report was not available for review at the time of this writing, and the cause and manner of death remained pending.

The subject child was considered healthy with no underlying medical conditions, and was not ill in the days leading up to her death. At the time of the fatality, she resided with her mother and 15-year-old brother (SS). Both children had the same father (BF), and although he did not live in the home, he visited with them regularly. The sibling's safety was assessed throughout the investigation with no concerns noted. Neither the father nor the sibling were present for the fatal incident involving the subject child.

It was discovered on the night of 12/9/17, the mother and subject child were at an aunt's (MA) home visiting with family. Also present that night were the subject child's two female cousins, 9 and 4 years old (CO1 and CO2, respectively), an unrelated 9-year-old female child (OC), and the aunt's boyfriend. There were varying accounts of the events leading up to the incident, but interviews revealed the children were playing together in the 9-year-old cousin's bedroom for approximately one hour, while the adults were in a different room. The children reported the subject child was playing inside the walk-in bedroom closet, with a scarf that had been tied to a pipe that they used to swing on. At approximately 10PM, the 4-year-old cousin found the subject child unresponsive inside the closet, and yelled for her sister. The other two children responded and found the subject child not breathing. The 9-year-old cousin ran to the mother and aunt for help. The mother found the subject child on the floor of the closet, and brought her to a couch where she began CPR. The aunt contacted 911, and Emergency Services responded to the home. First responders took over resuscitative efforts, and transported the subject child to the hospital. She was pronounced deceased at 11:37PM. Although it was not yet determined what caused the subject's child death, there was speculation she had accidentally hanged herself on the scarf in the closet; however, the children were not forthcoming with further information when interviewed. Initial conversations with an Emergency Room physician noted the subject child may have suffered from an arrhythmia.

From the time the investigation began to the time of this writing, MCDHS met with and interviewed the mother, father, sibling, and all other individuals present the date of the fatal incident. Several collateral sources were also contacted. MCDHS assessed home environments and the safety of the children throughout the investigation, and offered services to all individuals effected by the subject child's death. Law enforcement did not file any charges in relation to the fatality. MCDHS did not complete the 30-Day Safety Assessment nor the 30-Day-Fatality Report timely, and did not provide Notice of Existence Letters within the required 7 days. MCDHS had knowledge that the father had a permit to carry a firearm, and was carrying the firearm when he arrived at the hospital on the date of the fatal incident. The record did not reflect if safety regarding the firearm was discussed, such as where it was stored during visitation with the children, or if

the sibling had knowledge of the weapon or access to it at any time. The investigation remained open at the time of this writing, and the allegations had yet to be determined.

PIP Requirement
MCDHS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) MCDHS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, MCDHS will review the plan(s) and revise as needed to further address ongoing concerns.

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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The investigation remained open at the time of this writing. Sufficient information was gathered to assess the SS's safety.

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:
The level of casework activity was commensurate with the case circumstances. The investigation remained open at the time of this writing.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:	Failure to provide notice of report
Summary:	Notice of Existence Letters were not mailed/delivered until 12/28/17.

Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	MCDHS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Fatality Report was due on 1/9/18, and not completed until 1/17/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The 30-day Fatality Report must be documented in a template in Connections within 30 days of the receipt of a report alleging the death of a child because of abuse or maltreatment.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	MCDHS did not complete a 30-Day Safety Assessment until 1/17/18. The assessment was due on 1/9/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	MCDHS must complete a safety assessment at 30 days for reports of a child fatality, unless there are no surviving siblings or children in the household. This is in addition to the 24-hour assessment, the initial 7-day assessment and the conclusion safety assessment that must be completed within seven days prior to closing the case.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/09/2017 **Time of Death:** 11:37 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: 10:45 PM
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
- ☒ Playing
- ☐ Other
- ☐ Working
- ☐ Eating
- ☐ Driving / Vehicle occupant
- ☐ Unknown

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	Deceased Child	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Other Household 1	Father	No Role	Male	37 Year(s)

LDSS Response

On 12/10/17, MCDHS received a report regarding the death of SC. MCDHS began the investigation within 24 hours and coordinated with LE. During this time, MCDHS learned there was a SS and promptly assessed his safety. MCDHS also observed the home where the incident occurred, and spoke with OC who was present during the incident. OC stated she and CO1 found SC in CO1's closet, standing, with "watery" eyes, and they went to get an adult; OC did not provide any further information. There were no safety concerns noted regarding the home environment; however, LE discovered a scarf with a loop in it affixed tightly around a pipe inside the closet in which SC was found.

Through interviews, MCDHS discovered SC was a healthy child and had not been ill in the days leading up to her death. It was learned BF and SS were not present when SC was found in distress; SS had been at a relative's home for the day, and BF had not seen SC since 12/17/17. Both were interviewed but could provide no details surrounding events that occurred.

SM was interviewed by MCDHS in her home on 12/12/17. SM explained on 12/9/17, she and SC spent the day with family and attended a birthday party. SM stated she and SC stayed at the party until 8PM, and recalled SC had cried several times due to other CHN not playing with her or sharing their toys, which SM said was unusual behavior for SC. SM stated SC appeared fine otherwise. At approximately 9PM, SM and SC went to MA's home to spend time with MA, CO1, CO2, OC and MA's boyfriend. SM stated the CHN were primarily playing in CO1's bedroom, while SM, MA, and MA's boyfriend were in another room. SM reported at 10PM, CO1 ran to MA and told her SC was not breathing. SM went into CO1's room and found SC on the floor of the walk-in closet with her back against the wall. SM said she picked SC up and brought her to the living room where she laid her on the couch. MA called 911, and SM began CPR. SM said SC began vomiting. EMS arrived shortly after and transported SC to the hospital where she was pronounced deceased.

On 12/12/17, MCDHS also met with MA, CO1 and CO2 in their home. CO1 reported the night of the incident, she, CO2, OC, and SC were all playing in her bedroom, and then she and OC went into the kitchen. CO1 explained her sister yelled, so she and OC ran into the bedroom. CO1 said she saw SC lying on top of a desk, not breathing. CO1 said she then ran to get MA and SM. CO1 said there was a "string" in her closet, which she would use to swing on and watch TV. When MCDHS asked if SC had been using the "string," CO1 would not respond or provide any clear detail. CO1 stated MA asked her to take the "string" down, because that was where SC was "hanging" and they felt guilty. CO2 was also interviewed on this day and reported SC was "on the string" in CO1's room, and then she found SC on the floor and she "was dead." Due to her age and development, she could not provide any further information. MA was also interviewed and her account of events was consistent with SM's. MCDHS later clarified the string being referred to was the scarf affixed on the pipe seen during the initial home visit.

MCDHS spoke with collateral contacts, including LE and the ER Dr. MCHDS reviewed a police report from LE that contained a statement made by MA's boyfriend. MA's boyfriend reported to LE that he was in the kitchen with the other

adults when the CHN came in and said something was wrong with SC; he provided no further information. The ER Dr. reported to MCHDS that SC may have suffered from a possible arrhythmia. LE reported the ME found no evidence of ligature marks or trauma on SC's body. At the time of this writing, the final autopsy results remained pending, and there were no criminal charges filed against any of the adults present on the date of the incident. MCDHS offered all individuals preventive and grief service referrals. At the time of this writing, the investigation remained open.

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
Comments: This fatality investigation was conducted by the Monroe County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Monroe County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045768 - Deceased Child, Female, 4 Yrs	045769 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending
045768 - Deceased Child, Female, 4 Yrs	045769 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending

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 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: The SS did not need to be removed as a result of this fatality investigation or for reasons unrelated.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Family members accepted services from MCDHS in response to the fatality. The record does not reflect if they had begun to engage in services at the time of this writing.

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? Yes
Explain:

MCDHS offered grief and trauma services to the family, which included counseling for the SS. The parents accepted services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS offered preventive, grief and trauma services to the family, which they accepted. It is unclear in the case record if they had begun to engage. MCDHS also referred the family to a Family Advocate surrounding a need for assistance with funeral costs.

History Prior to the Fatality

Child Information

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

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

3/2005: IND for IG against BF regarding SS.
8/2013: UNF for IG and PD/AM against SM regarding SC.

Known CPS History Outside of NYS

There is no known CPS 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