Child Fatality Report

Report Identification Number: RO-20-009

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

Issue Date: Oct 19, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 8 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 05/26/2020
Initial Date OCFS Notified: 05/26/2020

Presenting Information

An SCR report was received which stated that on 5/24/20, the mother put the 8-month-old subject child in her crib to sleep. The mother then went downstairs to tend to the siblings. At some point, the mother asked the 5-year-old sibling to bring a duvet cover upstairs, and the child did so. When the mother went back upstairs with the siblings, she heard gurgling noises coming from the subject child's crib. The mother found the duvet cover on top of the child, and the child was blue and unresponsive. The child was brought to the hospital and placed on life support; however, was removed from such on 5/26/20 and declared deceased at 10:55AM.

Executive Summary

This fatality report concerns the death of an 8-month-old female subject child that occurred on 5/26/20. The child died during an open preventive services case that was initiated by the Monroe County Department of Human Services (MCDHS) on 5/5/20. This services case was opened due to the mother's ongoing needs pertaining to caring for her children. A report was made to the SCR on 5/26/20 with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother. MCDHS completed a thorough investigation into the death of the child. An autopsy was completed; however, the results were pending at the time of this writing.

An initial SCR report was received by MCDHS on 5/24/20 with allegations of Internal Injuries, Inadequate Guardianship and Lack of Supervision against the mother. The allegations in this report were regarding the injuries the child sustained that led to her death. At the time of the incident, the child resided with her mother and three siblings, ages 1, 5, and 8 years old. Two other siblings, ages 14 and 15 years old, resided with their maternal grandmother and were not present when the incident occurred. Paternity had not yet been established regarding the child; however, a potential biological father was identified. The investigation revealed that on the evening of 5/23/20, the child was put to sleep in her crib at approximately 7PM. The mother and the 8-year-old sibling fell asleep in the mother's bed sometime after midnight. The mother awoke shortly thereafter due to hearing noises coming from the child's crib. When the mother checked on the child, she found a duvet cover on top of her. The mother removed the cover and saw the child was blue and gasping for air; the child also began seizing. Emergency services were called and they transported the child to the hospital where she was placed on life support. After extensive testing, the child showed no brain activity and the mother eventually made the decision to cease life saving measures. The child was declared deceased on 5/26/20 at 10:55AM.

From the time the investigation began to the time of its closure, MCDHS interviewed family members and numerous collateral sources. The mother reported she did not recall the duvet blanket being in the child's crib when she was put to sleep; however, it may have been within the child's reach on a nearby storage container. It remained unknown how the duvet cover ended up on top of the child. Law enforcement found no criminality on behalf of the mother. MCDHS found no evidence that the mother placed the child at risk of harm, and therefore, unfounded the report. The services case remained open and ongoing at the time of this writing.

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:
MCDHS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving siblings.

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 case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the 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: 05/26/2020 **Time of Death:** 10:55 AM

Date of fatal incident, if different than date of death: 05/24/2020
Time of fatal incident, if different than time of death: 12:01 AM

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
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ 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	Deceased Child	Alleged Victim	Female	8 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Other Household 1	Sibling	No Role	Male	15 Year(s)
Other Household 2	Sibling	No Role	Female	14 Year(s)

LDSS Response

On 5/26/20, MCDHS received a subsequent fatality report regarding the death of SC. An initial SCR report was received on 5/24/20, after SC was found unresponsive in her crib and placed on life support. Upon receipt of the initial report, MCDHS began gathering information about the family and the events leading up to SC's injuries. The SS were observed and assessed as safe. On 5/26/20, SM made the decision to cease life saving measures as SC was declared brain dead, and SC died on that same date. MCDHS initiated the fatality investigation within 24 hours after the report was received and coordinated their efforts with their multidisciplinary team. It was learned MCDHS had been involved with the family since 5/5/20, after a voluntary preventive services case was opened to address SM's struggles with caring for 4 CHN on her own. That services case was ongoing at the time of SC's death.

On 5/26/20, MCDHS and LE met with SM at a relative's home. SM reported on 5/23/20, she and the CHN were at MGM's until approximately 7PM. SM said when they arrived home, SM asked the 5yo SS to bring a duvet cover that was in the living room upstairs. SM stated the SS put the duvet cover somewhere in SM's room but did not know where. The 8yo SS brought SC upstairs and placed SC in her crib to sleep. SM stated the older SS were in her bedroom sitting in bed with her until around midnight; SC was asleep in her crib in the same room. SM recalled after midnight when the CHN

were finally asleep, she heard a strange noise coming from the crib. SM said she checked on SC and found the duvet cover on top of her; she removed it and SC was blue, struggling to breathe. SM stated the 8yo SS was the only other CH in the room at that time. SM stated she called 911 and picked SC up and SC began having seizures. SM said SC was admitted to the hospital and was found to have swelling around her brain with no brain activity. SM reported after numerous tests, SC was taken off life support on 5/26/20. SM stated she did not know how the blanket got into SC's crib, and thought maybe it was in her reach and she grabbed it, or it may have fallen onto her somehow.

On this same date, the 8yo SS was also interviewed. The SS' story corroborated SM's recollection of events. The SS explained she did not notice the duvet cover in the room prior to SM finding it on SC. The other SS were also interviewed on this date; however, they were not in the room at the time SC was found in distress and had no information surrounding the incident. The CHN were all observed and assessed as safe. MCDHS then interviewed the 5yo SS. The SS had knowledge that SC died; however, no details surrounding the incident. He said he did not remember anything about helping SM with a blanket. The SS denied any safety concerns at home.

On 5/27/20, MCDHS observed the family home and the bedroom where the incident occurred. The bedroom had a queen-sized bed and two cribs approximately 2 feet away from the bed. One crib was filled with items and SM stated that crib was not used. The other crib was where SC slept and had a small toy and small pillow inside. Between the cribs was a plastic dresser with 2 storage bins stacked on top of it. SM explained if the duvet cover was placed on the bins, SC may have been able to grab it and pull it on top of her. SM stated she could not remember seeing the duvet cover in the crib or around it prior to the incident.

Throughout the investigation, MCDHS assessed the safety of the SS and spoke with numerous collateral sources, including biological fathers, medical staff, the pediatrician, and the case manager of the open services case. There were no criminal charges brought against SM regarding SC's death. Appropriate services were offered in response to the fatality. MCDHS found no evidence SM's actions or inaction led to the death of SC, and therefore unfounded the allegations.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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 MDT.

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
055087 - Deceased Child, Female, 8 Mons	055088 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
055087 - Deceased Child, Female, 8 Mons	055088 - Mother, Female, 33 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

Additional information:

MCDHS interviewed the family and appropriate collateral sources. One of the biological fathers was incarcerated and unable to be interviewed. Progress notes and other documentation were completed and entered timely.

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 the family appropriate services in response to the SC's death.				

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 report.				

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Prevention Services

Additional information, if necessary:
MCDHS provided the parents with bereavement counseling referrals. MCDHS also provided the parents with information on assistance with funeral costs. Prevention services were already in place prior to the death of SC.

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:
A preventive services case was open at the time of the fatality. Additional services were offered to address the loss of SC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
A preventive services case was open at the time of the fatality. Additional services were offered to address the loss of SC.

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? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

☒ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/07/2020	Deceased Child, Female, 4 Months	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 4 Months	Mother, Female, 32 Years	Lack of Medical Care	Substantiated	

Report Summary:
This SCR report was received with concerns SC, then 4-months-old, was born premature and in need of several medications and ongoing follow-up doctor's appointments. The report alleged SM failed to bring SC to her needed appointments and was not giving SC her medication.

Report Determination: Indicated | **Date of Determination:** 04/17/2020

Basis for Determination:
MCDHS met with the family and spoke with collateral sources. It was determined SM was struggling with the care of her children and was also having issues with her medical insurance. With MCDHS' assistance, SM was able to bring SC to her appointments and refill her medications. By the conclusion of the investigation, SC was only prescribed one medication and was up to date with her vaccinations. A preventive services referral was offered and accepted by SM. The allegations were indicated, and the case was closed.

OCFS Review Results:
This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/23/2018	Sibling, Female, 6 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Female, 6 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns the children were living in deplorable conditions, were dirty, not bathing and covered with flea bites.

Report Determination: Unfounded | **Date of Determination:** 05/09/2019

Basis for Determination: MCHDS interviewed family members and collateral sources. The home was observed on more than one occasion to be free from safety hazards and was not in deplorable conditions. The CHN were observed clean and free from bites. The investigation was unfounded and closed.
OCFS Review Results: This investigation met all statutory requirements.
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

CPS - Investigative History More Than Three Years Prior to the Fatality

From 2006 to 2009, the mother was named as a subject in 2 indicated reports with common allegations of IG, LS, and LMC.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 05/04/2020

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine

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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: A community based prevention agency provided services to the family.				

Preventive Services History

A voluntary preventive services case was opened on 5/5/20, as SM struggled with caring for her four children alone and had difficulty maintaining their medical needs. The case remained open and ongoing at the time of this writing.

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