Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-18-003

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

Issue Date: May 29, 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: 8 month(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 01/25/2018
Initial Date OCFS Notified: 01/25/2018

Presenting Information

An SCR report was received alleging that the SM placed the SC to sleep in a broken crib that she purchased from a thrift store, despite her knowledge that the crib railing was faulty. On the morning of 1/25/18 the SM checked on the SC and he was breathing. The SM checked on the SC hours later and found the SC positioned between the crib railing and mattress. The SC was not breathing. The SC was an otherwise healthy child.

Executive Summary

This report concerns the death of the 8-month-old male SC. Monroe County Department of Human Services (MCDHS) received an SCR report regarding the SC's death on 1/25/18. The SC was an otherwise healthy child and had no preexisting medical conditions. The SC was regularly placed to sleep in a crib that had been purchased second hand by the SM. The SC's crib was broken and the railing did not function properly. The SM historically had mechanical issues with the side railing of the crib.

On 1/24/18, the SM placed the SC to sleep in his crib. The SM checked on the SC twice throughout the night. On 1/25/18 the SM found the SC unresponsive, his body wedged between the crib mattress and crib railing. The SM called for emergency services. The SC was deceased when EMS arrived at the home and he was not taken to the ER.

The ME responded to the SC's home to transport the SC for autopsy. The ME found no outward signs of trauma when looking at the SC's body. The cause and manner of death were pending the final autopsy report.

LE jointly investigated with MCDHS. There is no documentation in the case record regarding the outcome of the criminal investigation.

MCDHS assessed the safety of the SS and offered the SM bereavement services and financial assistance to purchase household items. The BF of the SC and BF of the SS were notified of the SCR report and interviewed. MCDHS learned the SM previously had a child that died. The death allegedly occurred in 2012. The SM reported the child was born premature and was hospitalized from birth until her death due to medical issues. MCDHS requested records from the state where the child was born and died. There was no further documentation that the records were received or reviewed.

MCDHS gathered much of the information regarding the fatality in the first few days of the investigation. There were several concerns reported by the BF's that were not addressed with the BM at the time of this writing. Additionally, MCDHS smelled marijuana during a home visit with the SM and SS and did not address their observations with the SM. MCDHS did not complete the 30-day fatality report or 30-day safety assessment in Connections. MCDHS did not follow up with collateral contacts that may have provided pertinent information regarding the SM's care of the SC and SS. Although MCDHS spoke with the daycare provider at a chance encounter, they did not initiate further contact to gather additional information.

At the time of this writing the CPS investigation remained open and no determination had been made.

PIP Requirement

MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS will review the plan and revise as needed to 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?** N/A
- **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

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:
A determination had not been made at the time this report was written.

Required Actions Related to the Fatality

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

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:	A 30-Day Fatality Report was not completed.
Legal Reference:	CPS Program Manual, VIII, B.2, p.4
Action:	MCDHS will complete 30-Day Fatality Reports in Connections within 30-days of receiving the SCR report alleging the death of a child as a result of abuse or maltreatment.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	MCDHS did not complete a safety assessment regarding the SS at the 30-day mark of the investigation.

Child Fatality Report

Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	MCDHS will complete a safety assessment at 30 days for reports of a child fatality, unless there are no surviving siblings or children in the household.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/25/2018 **Time of Death:** Unknown

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? 3 Hours
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	Male	8 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)

LDSS Response

On 1/25/18, MCDHS received an SCR report regarding the death of the SC. MCDHS immediately began their investigation and worked collaboratively with LE.

MCDHS learned the SM's work hours varied, and SS and SC went to a daycare provider while the SM worked. It was not uncommon for the CHN to go to bed late and sleep in during the mornings. MCDHS learned the SC and SS were put to bed at about midnight on 1/25/18. The SC was placed in his crib on his back. The SM checked on the SC at 3:00AM and 9:00AM and he was breathing and had changed sleeping positions. The SC could not pull himself to a standing position and was not yet crawling. The SM again went to check on the SC at 12:30PM and found the SC wedged between the side of the mattress and side railing. The SC was unresponsive and the SM picked him up and called 911. The 911 operator gave the SM CPR instructions, but as she was talking to them EMS arrived. The SM placed the SC on the couch in the downstairs of the home and opened the door for first responders. EMS determined the SC was deceased and he was not transported to the ER. The ME was notified and responded to the home.

The SM had purchased the SC's crib used a couple of years prior. The crib was missing a post that allowed the railing to screw into the base, causing the railing to be unattached to the rest of the crib. The railing could be easily forced away from the rest of the crib. The SM walked LE and MCDHS through the room where she found the SC and further explained his positioning. The SC was found with his face toward the mattress and pressed into it. The SC's back was facing the broken railing and his body was wedged between the mattress and railing; his feet were suspended off the floor. There was an impression on the crib sheet consistent with the SC's face. MCDHS observed a "Boppy" pillow, blankets and a bottle in the crib.

MCDHS spoke with the MGM, while she was sitting in her car outside the SC's home. Presumably, the SM had called her after discovering the SC. The SS was in the car with the MGM and was assessed to be safe. The MGM advised MCDHS that the SM and SS would be coming to stay at her home for awhile. MCDHS assessed the safety of the home later that day. MCDHS also spoke with the daycare provider while she was at the SM's home. She reported that she went to the home to offer support after hearing about the SC's death. She reported driving the SC and SS home to the SM last night when she returned home from working. She stated the CHN were well cared for. She agreed to speak further with MCDHS and LE, but there was no documentation that follow up contact was made.

The BF of the SC had been incarcerated since 9/21/17. The BF was interviewed and stated he did have concerns previously that the SM suffered from depression after having the SC. He said at times she would be very cheerful and then quickly become angry. He attended the SC's funeral and stated the SM appeared calm, given the circumstances. The BF of the SS was interviewed over the telephone as he lived out of the state. He did not regularly see the SS, but had phone contact with the SM regarding the SS. He stated he had been concerned in the past about the relationship between the SM and BF of the SC, because he believed there was abuse. He also expressed concern regarding injuries his daughter had in 2016 or 2017. He stated that when the SC was first born, the SM sent him texts implying she was overwhelmed with the care of the SC. He offered to forward the texts and pictures of the SS previous injuries to MCDHS.

MCDHS faxed a release of information to the pediatrician for the SS and SC, but there is no documentation that the dr. responded regarding the SC. The SM reported the SC was not ill or taking medication at the time of his death.

There is no documentation that whether or not the SM previously received safe sleep education. The SM denied any MH concerns or alcohol/substance abuse.

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
044001 - Deceased Child, Male, 8 Mons	044003 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Pending
044001 - Deceased Child, Male, 8 Mons	044003 - Mother, Female, 25 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?	☒	☐	☐	☐

Additional information:

The Daycare Provider gave her contact information to MCDHS after a brief encounter; MCDHS did not follow up with her as a collateral.

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?	☐	☐	☒	☐
Explain: There was no safety assessment completed at the 30-day mark in the investigation.				

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: The Risk Assessment was not completed at the time this report was written.				

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
No Service needs were identified.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Preventive Services and Grief/Trauma Counseling were offered. Additionally, MCDHS assisted the SM with the purchase of cleaning supplies.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No

Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There is no CPS history for the SM, SC or SS in Connections.

Known CPS History Outside of NYS

MCDHS requested CPS records from another state where the SM previously lived and the state did not respond. Therefore, it is unknown if the SM has a history outside of New York State.

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

Additional Local District Comments

MCHDS has reviewed this draft fatality report. This report is factually accurate.

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

Explain: In light of the circumstances surrounding the death of the SC, OCFS recommends MCDHS contact members of their local Child Fatality Review Team (CFRT) to discuss outreach and education to the thrift store where the SM purchased the SC's crib.