



Report Identification Number: RO-19-002

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

Issue Date: May 22, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

- A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- The death of a child for whom child protective services has an open case.
- The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child’s family; any extraordinary or pertinent information concerning the circumstances of the child’s death; whether the child or the child’s family received assistance, care or services from the social services district prior to the child’s death; any action or further investigation undertaken by OCFS or the social services district since the child’s death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child’s household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child’s siblings or other children in the household.**

OCFS’ review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS’ assessment and the performance of these agencies.



Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		



Case Information

Report Type: Child Deceased
Age: 9 month(s)

Jurisdiction: Monroe
Gender: Female

Date of Death: 01/06/2019
Initial Date OCFS Notified: 01/06/2019

Presenting Information

An SCR report received on 1/6/19 alleged that on 1/5/19, the 9-month-old child was put to bed in her crib at 7:00 PM. On 1/6/19, the mother checked on the child via the baby monitor at 5:00 AM and the child appeared to be sleeping. At 6:20 AM, the mother physically checked on the child and found her unresponsive. The mother moved the child to the parents' bedroom and attempted CPR while the father called 911. EMS and LE responded to the scene. The child was pronounced deceased at the home at 7:35 AM. The child had no known preexisting medical condition and was an otherwise healthy child. There were no visible injuries to the child. The parents were the sole care givers for the children.

Executive Summary

This report concerns the death of a nine-month-old female child that occurred on 1/6/19. Monroe County Department of Human Services (MCDHS) received an SCR report on 1/6/19, regarding the fatality. On 1/5/19, at approximately 7PM, the mother placed the child in her crib to sleep; the father and 2yo surviving sibling were also home. The mother was awoken at approximately 5:00 AM by the 2yo surviving sibling. After the mother checked on the surviving sibling she went in to the child's room to check on her. The mother found the child face down in her crib and unresponsive. There was blood on the crib sheet. The mother picked her up and brought her to the father who called 911. EMS arrived and the child was already deceased. The medical examiner arrived at the residence and pronounced the child deceased at 7:35AM. MCDHS and law enforcement were at the scene and conducted a full tour of the home. The crib was observed free from objects with only a fitted sheet on the mattress. The parents followed safe sleep guidelines and denied the child had any health issues.

MCDHS assessed the safety of the 2yo surviving sibling. MCDHS observed and attempted to interview her. There were no immediate concerns for the care of the surviving sibling. MCDHS interviewed the parents, family members and collateral contacts who provided information about the safety of the child. MCDHS requested and reviewed all pertinent medical records of the child as well as the surviving sibling. There were no noted concerns for the care of either child at that time.

The medical examiner's preliminary autopsy report findings was undetermined and pending toxicology reports. There were no physical signs of abuse or neglect of the child. On 1/18/19, the toxicology report came in and the medical examiner reported the child died from a methadone overdose.

MCDHS and law enforcement immediately secured warrants for the parents' home as well as the neighbor's home. The warrant was secured for the neighbor's home as that was the only other place the child had been on the evening of 1/5/19. The parents agreed to a temporary safety plan for the surviving sibling to stay with the grandparents pending further investigation. The parents fully cooperated with the investigation and underwent immediate drug testing. Their tests results were negative and there were no drugs found in their home. Through the investigation it was learned the neighbor's mother who had been staying with them recently, had been prescribed 10mg of methadone for a medical condition. It was believed the relative previously dropped a pill in the kitchen area where the children had been playing that evening. No one saw the child ingest anything while playing on the floor.

The medical examiner office verified the amount of the drug found in the child and the reported dosage were consistent with the explanations provided by all parties who were interviewed. The manner of death was determined to be accidental.



There were no criminal charges pursued in relation to the fatality.

All safety and risk assessments were done correctly and on time. MCDHS completed the required reports timely and accurately.

On 2/12/19, the allegations for DOA/Fatality and IG against the parents for the child were unsubstantiated. There was no credible evidence that the death of the child was caused by anything the parents did or failed to do. The family was referred to and accepted trauma services. There were no other noted safety concerns for the care of the surviving sibling. Follow up visits were conducted by MCDHS prior to closing. The case was unfounded and closed.

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:

N/A

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:

N/A

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: 01/06/2019

Time of Death: 07:35 AM

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?

Yes

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: 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	9 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 1/6/19, MCDHS received the fatality report from the SCR, initiated their investigation and coordinated efforts with law enforcement. MCDHS contacted the source of the report, completed a CPS history check, and notified the medical examiner and district attorney.

On 1/6/19, MCDHS coordinated with law enforcement and met them at the families residence. MCDHS interviewed the parents separately and their accounts of the events leading up to the death of the child were consistent. The parents told MCDHS that they had gone to a dinner party on the evening of 1/5/19 at their next-door neighbor's home. While at the party the children were playing in the kitchen where the parents and neighbors were gathered. The child had been crawling on the floor. The mother said at about 6:30 PM the child fell asleep in her arms. The parents said they walked home at 7:00



PM. The parents said when they arrived home the mother changed the child for bed and placed her on her back in the crib to sleep. The mother said the 9-month-old child had been rolling over onto her stomach to sleep for a few months. The mother checked the video baby monitor throughout the night and the child had turned over onto her stomach and appeared to be sleeping. At 5:00 AM the 2yo surviving sibling had awoke and the mother went to the sibling's room to check on her. Sometime after that she went to the child's room to check on her. The mother said she found the child on her stomach and she was cold and stiff to the touch. The mother observed blood on the sheet. The mother said she lifted the baby into her arms and went to the father and he called 911. EMS arrived and the child was pronounced dead at the home.

MCDHS was at the home when the medical examiner arrived to assess and transport the child for the autopsy. After interviewing the parents, MCDHS assessed the safety of the 2yo surviving sibling. They toured the home and there were no noted concerns for the surviving sibling's safety.

MCDHS obtained information from the medical examiner, family members, the neighbors, the surviving sibling and the child's pediatrician. The children's pediatric records noted no concerns for the care of the children by the parents. MCDHS verified with the parents that they were aware of safe sleep practices and observed the crib on the day of the reported fatality, noting the parents were following safe sleep guidelines. MCDHS offered the parents referrals for trauma services and they accepted.

On 1/18/19, the medical examiner reported the child's toxicology report came in and the child died of a methadone overdose. Law enforcement secured a warrant for the parents' and neighbor's homes. MCDHS responded to the residence with law enforcement and made a safety plan with the parents and the grandparents. They all agreed the 2yo surviving sibling should stay with the grandparents pending further investigation. The parents fully cooperated and underwent drug testing. The parents were negative for any drugs and there was no evidence found in their home of any drug or alcohol misuse. The neighbor's home was searched as well and the neighbor was a doctor who had prescription drugs found in a secured location in the home. After comprehensive interviews it was determined that a family member who had been staying with the neighbor's family had been prescribed 10mg of methadone for a medical issue. This family member had kept the medication on the counter in the kitchen. It was believed a pill may have been dropped unknowingly on the floor where the child had been crawling.

The medical examiner verified with MCDHS and law enforcement the facts gathered were consistent with the toxicology report. The manner of death was believed to be accidental.

The safety plan was lifted and the surviving sibling remained in the care of her parents.

Official Manner and Cause of Death

Official Manner: Accident

Primary Cause of Death: From an injury - external cause

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
049939 - Deceased Child, Female, 9 Mons	049942 - Father, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
049939 - Deceased Child, Female, 9 Mons	049942 - Father, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	-------------------------------------	--------------------------	--------------------------	--------------------------

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain:
N/A

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain as necessary:
The 2yo remained in the care of her parents

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>					



Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:
 As a result of the autopsy results the parents agreed to undergo drug testing. Both of the parents tested negative for drugs.

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 fetal alcohol effects or syndrome

With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

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

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

There was no history more then three years prior to the fatality.

Known CPS History Outside of NYS

MCDSS contacted Pennsylvania and there was no known history outside 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