Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-19-034

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

Issue Date: Feb 21, 2020

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

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 09/27/2019
Initial Date OCFS Notified: 10/04/2019

Presenting Information

On 10/4/19, the death of the six-month-old infant was reported to OCFS by the Monroe County Department of Human Services (MCDHS) through the required Agency Reporting Form 7065. The infant died on 9/27/19, due to severe smoke inhalation and burns sustained from a house fire.

Executive Summary

On 9/28/19, MCDHS was notified by hospital staff that the six-month-old infant passed away on 9/27/19 at 7:57 PM. MCDHS had an open CPS investigation at that time, which was received on 9/23/19, that alleged the home caught on fire and the cause was suspicious. The mother and infant were rescued from the second floor of the home and hospitalized due to smoke inhalation and severe burns. The mother passed away from her injuries on 9/25/19. The mother and infant were the only ones who resided in the home and the parents had no other children.

The father of the infant had been incarcerated since prior to the infant's birth on an unrelated matter. MCDHS spoke to the father on the phone and he expressed no concerns for the mother's care of the infant. He did not think the mother did anything to cause the fire. He said the maternal aunt told him the mother and infant had been staying with another relative since the electricity was shut off in the home. The mother and the relative had an argument on the evening of 9/22/19, so the mother took the infant back to the home to sleep for the night. The father was concerned that someone else may have entered the home and caused the fire. Bereavement services were discussed with the father, although he had limited access to services due to incarceration.

Death certificates were requested and not yet received at the time this report was written. Hospital staff reported the mother and infant both had to be resuscitated and they were on life support until their death. Hospital records stated the infant was treated for acute respiratory failure with hypoxia and hypercapnia, cardiac arrest, burns, metabolic acidosis, compartment syndrome, Hypoxic Ischemic Encephalopathy and severe acute respiratory distress syndrome.

Law enforcement reported the cause of the fire remained undetermined. They thought candles may have been the cause and it did not appear the mother did anything suspicious. The investigation remained open with the arson task force.

MCDHS unfounded the allegations of the SCR report due to a lack of credible evidence the mother's actions caused the fire and the case was closed.

PIP Requirement
For issues identified in a historical case, MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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:**
  - **Safety assessment due at the time of determination?** N/A

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:
The decision to unfound and close the case was appropriate.

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 has detail of the consultation.

Explain:
Casework activity was commensurate with best casework practice.

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: 09/27/2019 **Time of Death:** 07:57 PM

Date of fatal incident, if different than date of death: 09/23/2019
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
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	6 Month(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)
Other Household 1	Father	No Role	Male	23 Year(s)

LDSS Response

MCDHS conducted a thorough investigation of the incident. They searched SCR history and spoke to law enforcement, hospital staff and the father. Hospital records and law enforcement records were received and reviewed. MCDHS were unsuccessful in their attempts to speak to the maternal aunt.

Law enforcement records showed the fire department responded to the home at 8:00 AM on 9/23/19 for a fire. The electricity and gas meter had been locked out since 9/13/19, so it was determined the fire was not caused by anything electrical or heat related. It was determined the fire started on the couch on the first floor and there were tealight candles found in the area. The mother and infant were found unresponsive on the second floor behind the bedroom door. The smoke detectors had batteries but did not appear to be working.

Hospital records showed the infant's EEG was consistent with severe anoxic brain injury. A brain death evaluation was completed on 9/26/19. The father visited the infant from prison and decided not to pursue further aggressive resuscitation. The maternal aunt was present when the infant passed away.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐

Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/04/2019	Deceased Child, Female, 3 Days	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
An SCR report alleged on 3/1/19, the mother gave birth to the subject infant and the mother tested positive for marijuana.

Report Determination: Unfounded
Date of Determination: 04/18/2019

Basis for Determination:
The allegations were unsubstantiated due to a lack of credible evidence. The infant was healthy and showed no signs of withdrawal. The mother appeared sober at all contacts, there were no drugs observed in the home, and the mother reported she quit smoking marijuana. The pediatrician, grandmother and friend were spoken to and they had no concerns for the infant. Substance abuse services and mental health services were offered and declined.

OCFS Review Results:
MCDHS provided safe sleep education to the mother and completed a plan of safe care. The mother was referred to Healthy Families and Lifetime Care Nursing. The mother had the necessary supplies for the infant, the infant appeared to be well-cared for, and the home was assessed to be safe. Safety assessments and the RAP were completed accurately and the mother and father were provided with the Notice of Existence. There were no documented attempts to interview the father, who was incarcerated.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
The father was provided with a Notice of Existence letter, although efforts to conduct an interview with him were not documented.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children and other persons named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

[redacted]

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS 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

MCDHS has reviewed this draft fatality report. We are in agreement with the facts presented.

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