Child Fatality Report

Report Identification Number: RO-19-005

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

Issue Date: Jun 20, 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: 4 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 01/30/2019
Initial Date OCFS Notified: 01/31/2019

Presenting Information

An SCR report alleged a 4-month-old infant was placed to sleep in a crib on 1/29/19 in the same room as the parents in an emergency shelter where the family resided. The father awoke between 4 and 5 AM the next day and found the child blue and unresponsive with mucus on and around her mouth and face; the mother was sleeping. The infant was found on her stomach with a blanket underneath her. EMS and LE were called, responded to the scene, and made efforts to resuscitate the child. She was transported to a hospital where she was admitted and subsequently pronounced deceased at 10:52 PM. The infant had been otherwise healthy. No cause of death was determined, therefore both parents were named subjects as they were the only adults with access to the infant.

An SCR report had been made on 1/30/19 regarding the fatal incident, prior to the fatality. In addition to the event, it was alleged the infant had a fever and congestion since 1/25/19 and neither parent had sought medical attention.

Executive Summary

This report concerns a 4-month-old infant who passed away on 1/30/19 while sleeping in an unsafe environment. An SCR report alleged she was hospitalized after being found unresponsive by her parents. When she died later that day, a subsequent report alleged the parents were responsible as the cause was unknown. It was also alleged the infant was sick in the days prior and the parents had not sought medical attention. Monroe County Department of Human Services (MCDHS) investigated the fatality.

Records were requested from the ME, who confirmed the death but noted the immediate cause and manner were pending further investigation. The final autopsy report had not been received at the time of this writing.

The infant had been placed to sleep for the night in her crib on 1/29/19. Early the next morning, her mother tried to feed her. When she refused the bottle, the mother swaddled her and placed her in the crib on her side atop blankets. Approximately an hour and a half later, the father found the baby unresponsive, face down in the blankets. The parents rushed out of the room seeking help. Staff at the shelter where they resided assisted with CPR and 911 was called. EMS responded and transported the baby to the hospital, where she died later that evening.

A physician specializing in child abuse examined the infant and opined she was too old to be swaddled safely given her age and developmental level. The physician noted had the baby not been swaddled, she may have been able to get herself out of an unsafe position.

According to the parents, the baby had congestion and difficulty breathing since 1/25/19. She was last seen by a pediatrician two months prior; she had no medical insurance. The parents used over-the-counter remedies for her illness. The physician specializing in child abuse was consulted about the illness with respect to alleged lack of medical care. Tests post-death showed the infant was positive for a virus known to present with cold-like symptoms. The physician said emergency care would have been required only if the baby needed oxygen, and there was no way to test whether that had been needed. MCDHS considered the parents' provision of care at home for the child's illness, and this allegation was unsubstantiated.

Law enforcement made no arrests. Given their interpretation that the death appeared to be due to unsafe sleep and thus accidental, the criminal investigation was suspended pending any new evidence or information.

The parents created an unsafe sleeping environment for the infant and slept while she was in immediate/impending danger of serious harm; both were indicated for inadequate guardianship. The allegation of DOA/Fatality was unsubstantiated due to the pending cause and manner of death; in addition, medical staff were unable to state whether the child's condition was a result of unsafe sleep or an acute respiratory illness.

The infant was the mother's only child. The father reported having six other children, only four of whom he identified, noting he was unsure if the other two children were biologically his. MCDHS documented the four half-siblings' whereabouts and assessed their safety; the information gathered was sufficient to determine there was risk, but no safety concerns. It was determined none of the siblings had contact with the father or had knowledge of the infant.

MCDHS conducted a thorough multidisciplinary investigation and recorded casework activity timely and accurately. MCDHS encouraged the parents to seek mental health and medical services to meet their untreated needs and discussed such services. Other areas of risk were identified, and MCDHS convened with their CAC's Family Advocate so the appropriate service referrals could be made, including those related to the fatality.

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:
Safety assessments were timely and appropriate. The determination of allegations was appropriate given the supportive evidence in the case.

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 activities were commensurate and complete throughout the investigation and the case was appropriately indicated and closed.

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: 01/30/2019 **Time of Death:** 10:52 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 05:39 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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? 45 Minutes
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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

MCDHS promptly responded to the SCR reports and thoroughly investigated the death by coordinating with LE and interviewing the family, medical and shelter staff, and various other relevant contacts.

The parents said around 4 AM on 1/30/19, the infant awoke and the mother tried to feed her but she would not eat. The mother put her back in the crib after swaddling her in a blanket. She placed the baby on her side atop another blanket with her back against the side of the crib; the mother went back to sleep. The father checked on the baby around 4:45 AM, saw her swaddled on her side, and wiped her nose. The father resumed sleeping, woke 15 minutes later, and got out of bed around 5:30 AM. He then found the baby face-down in the blanket. When he picked her up she was limp and her skin and hands were discolored. He woke the mother and ran out of the room with the baby seeking help. He called 911 while shelter staff started CPR with instructions from the 911 operator. EMS arrived and transported the child to the hospital. Life support was withdrawn when the child's condition failed to improve.

MCDHS visited the family's residence and observed the infant's crib in the same condition as when she was found unresponsive. It contained one large blanket (long enough to cover the sides of the crib), three smaller blankets (described as thick and fluffy) and two stuffed animals. MCDHS observed essential infant provisions, including appropriate remedies used by the parents to treat the baby's symptoms. Though the parents named the medications and remedies used, it was not noted whether anything was administered within 24 hours of the fatality. LE searched the room and found no evidence of drugs. MCDHS documented that their interactions with the parents on 1/30/19 revealed no suspicions of impairment from drugs or alcohol.

The parents denied prior knowledge of infant sleep safety, but a Dr. who previously saw the baby educated the mother on placing the baby on her back to sleep. The parents said the baby usually slept face-down and always slept with the blankets observed that day; the baby often pulled blankets over her face which they said did not concern them. They thought sleeping on her side would help with congestion. They confirmed she had not been seen by a Dr. since she was two months old.

MCDHS interviewed shelter staff who had information about the family and events following the incident. Both the shelter director and an administrator reported no concerns, noting the parents seemed to prioritize the child's needs over their own. It was said the mother often sought help from staff with parenting questions. Shelter staff had provided the crib, and though it was noted staff encouraged parents to use them, they did not monitor their use. It was not apparent staff provided safe sleep education.

MCDHS learned the father had other children and gathered information to assess their safety. The father said he had no contact with those children, which MCDHS confirmed. In Missouri, he had two 15-year-old children with one woman, one of whom he abused as an infant. He had not seen them in approximately 14 years, and MCDHS learned he had no parental rights; they had been adopted. In Florida, he had two children with a different woman, ages 4 and 5, one of whom he had never met and the other he had reportedly not seen since 2014. MCDHS spoke with their mother and learned the father had a violent history with her in the presence of her children. She said she had an OP against him and would not allow him to have contact with any of her children. MCDHS responded to this information by gathering documentation to confirm he was criminally charged with the incident disclosed, and that an OP was in place. Given the father's history of violence and DV, it may have been beneficial to engage the infant's mother alone to explore the dynamics of their relationship.

After service referrals were made, the investigation closed on 5/15/19.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Undetermined if injury or medical 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
Comments: This fatality was reviewed by the Monroe County Child Fatality Review Team in April, 2019.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050146 - Deceased Child, Female, 4 Month(s)	050145 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
050146 - Deceased Child, Female, 4 Month(s)	050145 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
050146 - Deceased Child, Female, 4 Month(s)	050144 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated
050146 - Deceased Child, Female, 4 Month(s)	050144 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
050146 - Deceased Child, Female, 4 Month(s)	050145 - Father, Male, 37 Year(s)	Lack of Medical Care	Unsubstantiated
050146 - Deceased Child, Female, 4 Month(s)	050144 - Mother, Female, 19 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents had no surviving children in their care such that a preventive case could be opened; however, several risk factors were identified and a referral was made to a Family Advocate at the CAC, who worked with the MDT team and family to make the appropriate referrals. MCDHS also gave the parents information on services for their most pressing need - mental health.

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 needs were identified for the surviving siblings whom MCDHS learned of, as it was not evident any of them knew of the subject child or her death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Mental health services were offered to the parents upon an identified need and they were encouraged to follow through, and other services were referred; however, it did not appear any services were used while the investigation was open and it was unknown if there was engagement in services after the case closed.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	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?	Yes

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 investigative history in NYS more than three years prior to the fatality.

Known CPS History Outside of NYS

The father had history as an indicated subject from a report dated 5/13/03 in the state of Missouri. He was indicated for internal injuries, subdural hematoma, and shaking. MCDHS was unable to get comprehensive information from CPS in Missouri on the abused child, but the father told MCDHS it concerned his biological child who was less than one month old at the time. MCDHS confirmed the associated criminal history, in which the father was charged with assault in the first degree and received a maximum sentence of ten years' incarceration. CPS in Missouri informed MCDHS that his two

children in that state have since been adopted and should not have contact with the father.

MCDHS requested CPS records from the states of North Carolina and Florida where the parents reported having recently resided, and found no history in those states.

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

Action:	During their investigation, MCDHS became aware of an incident of alleged child maltreatment in another state. MCDHS did not make a report to that state; however, New York State Social Services Law does not require mandated reporters acting in their professional capacities to make reports outside New York State. OCFS recommends that MCDHS consider developing a protocol for determining under what circumstances it may be appropriate to make an out-of-state report.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No