Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-20-002

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

Issue Date: Jul 06, 2020

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 21 day(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 02/01/2020
Initial Date OCFS Notified: 02/03/2020

Presenting Information

An SCR report was received that stated on 1/31/20, the mother laid the 21-day-old child down to sleep in a bassinet. Around 4:35AM on 2/1/20, the mother went to check on the child and found her unresponsive in the bassinet. The mother was unable to find her cell phone to call 911, so she went to a neighbor's house to make the call. The ambulance arrived but did not attempt to revive the child as she was already deceased. The mother had no explanation as to what happened to the child.

Executive Summary

This fatality report concerns the death of a 21-day-old female subject child (SC) that occurred on 2/1/20. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother (SM). Monroe County Department of Human Services (MCDHS) received the report and completed a thorough investigation into the child's death. An autopsy was completed; however, the final report was not yet completed at the time of this writing. The subject child lived with her mother, father, and two siblings, ages 3 and 5 years old. The subject child also had two half-siblings, ages 14 and 15 years old, who lived with their maternal grandparents.

The investigation revealed that on the night of 1/31/20, the mother was at home with the child and the two younger siblings while the father was at work. The mother put all three children to sleep in the same bedroom at 11:00PM. The child was placed on her back, swaddled, in her bassinet, and the siblings slept in the same bed together. The mother fell asleep in an upstairs bedroom shortly after putting the children to sleep. At approximately 4:00AM, the mother awoke and realized the child had not woken up in the middle of the night as she typically would. The mother went downstairs to check on the child and found her unresponsive in her bassinet. The mother could not find her phone and laid the child in the downstairs bedroom while she ran to a neighbor's house to call emergency services. The ambulance arrived several minutes later, but the child could not be revived. The coroner was contacted and later arrived at the home. The child was pronounced deceased at 8:19AM.

From the time the investigation began to the time of its closure, MCDHS met with family members and spoke with pertinent collateral sources. MCDHS offered the family appropriate services in response to the fatality. There were no concerns noted surrounding the safety of the surviving siblings. MCDHS found no evidence the mother's actions or inaction contributed to the child's death, and therefore unfounded and closed their case.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
    - **Approved Initial Safety Assessment?** Yes

- **Safety assessment due at the time of determination?** Yes

- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.

- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
MCDHS gathered sufficient information to appropriately determine the allegations and assess the safety of the SS.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/01/2020 **Time of Death:** 08:19 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: 04:34 AM
Did EMS respond to the scene? No
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? 5 Hours
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	21 Day(s)
Deceased Child's Household	Father	No Role	Male	40 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Sibling	No Role	Male	14 Year(s)
Other Household 2	Sibling	No Role	Male	15 Year(s)

LDSS Response

On 2/1/20, MCDHS received the SCR report regarding the death of SC, which occurred on that same date. MCDHS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. MCDHS learned there were four surviving siblings and worked promptly to assess their safety.

On 2/1/20, MCHDS completed a home visit to the family's residence, and LE was also present. MCDHS observed the home and noted no safety concerns. SM was not able to be interviewed at that time due to her emotional state; however, MCDHS did speak with BF. BF explained on 1/31/20, SM and the CHN went to BF's shop where he worked and visited him there until approximately 7:00PM. BF stated SM returned home with the CHN around 8:00PM. BF explained he stayed at his shop and next spoke with SM around midnight to let her know he would be coming home soon. BF reported he was so tired that he fell asleep at his shop and did not return home. BF said he received a call from MGM that woke him telling him what had happened to SC. BF denied SC had any health issues other than a diaper rash, and reported SC seemed normal and healthy in the days leading up to her death. BF stated he and SM were aware of safe sleep practices and SM was very strict about them; SC slept on her back in her bassinet, and if she fell asleep in her car seat, they would always be sure to put her in her bassinet. BF had no further information regarding the incident. On this same date, MCDHS was able to assess the safety of all SS and noted no concerns. The maternal grandparents were present and explained they would be helping with the SS while the parents grieved.

On 2/7/20, MCDHS again met with the family at the maternal grandparents' home, as that was where they were residing for the time being. The home was observed, and no safety concerns were noted. SM was interviewed and reported there was nothing out of the ordinary within the 24 hours leading up to SC's death, other than SC having a diaper rash. SM reported she only had SC and the younger SS with her at home on the night of 1/31/20; BF was at his shop and the older

SS were at the maternal grandparents' house for the night. SM stated all of the CHN went to bed at 11:00PM in the same room. SM said SC was in her bassinet, and the two SS were sharing a bed. SM explained SC was placed on her back in the bassinet wearing a swaddle and denied any other items in the sleeping area. SM stated she fell asleep in the upstairs bedroom and awoke in a panic around 4:00AM because SC never woke up in the middle of the night like she normally did. SM said she went downstairs and checked on SC and knew something was not right; SC was unresponsive so SM patted her back, breathed in her mouth and noticed blood came out. SM said she panicked and could not find her cell phone. She said she placed SC on the downstairs couch and knew "she was already gone." SM said she placed a blanket over SC and then ran to a neighbor's house to call 911. SM reported when she found SC that morning, she was still on her back, with her head to her side, but the swaddle was up a little bit higher than normal. On this same date, MCDHS spoke with the two oldest SS. Both siblings reported they lived at their grandparents' home and were not there when SC died. The two oldest SS lived with the maternal grandparents as they wanted to remain in the school they had been attending, after the family moved. The SS did not disclose anything concerning and were deemed safe. MCDHS attempted to interview the younger siblings; however, they would not engage or answer questions.

Throughout the investigation, MCDHS spoke with several collateral sources and family members. LE found no criminality on behalf of either parent. MCDHS offered the family appropriate services in response to SC's death. There was no evidence found to support the allegations in the report, therefore, MCDHS unfounded and closed the case.

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
Comments: This fatality investigation was conducted by the Monroe County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Monroe County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054332 - Deceased Child, Female, 21 Days	054333 - Mother, Female, 39 Year(s)	DOA / Fatality	Unsubstantiated
054332 - Deceased Child, Female, 21 Days	054333 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐

Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
MCDHS interviewed the family and appropriate collateral sources. Progress notes and other documentation were completed and entered timely.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐

During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: MCDHS offered the family appropriate services in response to the SC's death. The family accepted the services; however, they had not yet engaged at the close of the investigation.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The SS did not need to be removed as a result of this fatality report.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
MCDHS provided the parents and visiting nurse with bereavement counseling referrals. The record did not reflect if family planning services were discussed with the parents.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
MCDHS provided referrals for grief and bereavement counseling to the parents for the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS provided the parents and grandparents referrals for grief counseling and bereavement services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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 CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of 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