Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-18-001

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

Issue Date: Jun 08, 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: 9 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 01/03/2018
Initial Date OCFS Notified: 01/01/2018

Presenting Information

Two SCR reports were received on 1/1/18 and 1/3/18, which alleged at approximately 8AM, the subject child was found without a pulse and not breathing while in the care of her father. The child was laying on the floor, surrounded by pillows, when the father looked back and saw she was unresponsive. There was no explanation given for the child's condition. The child's mother was sleeping at the time, but awoke and called EMS. EMS transported the child to the hospital, and she was found to have swelling on her brain. The child died on 1/3/18, and the mother's role was unknown.

Executive Summary

This fatality report concerns the death of a 9-month-old female child (SC) that occurred on 1/3/18. Two reports were made to the SCR regarding SC: The first on 1/1/18, when SC was still in the hospital on life support, and the second on 1/3/18, after the SC died. The fatality report was received with allegations of IG, II, and DOA/Fatality against the child's father (SF), and the allegation of IG against the mother (SM). The final autopsy report was not available at the time of this writing, and the cause and manner of remained were pending.

The child was born healthy with no preexisting medical conditions. At the time of the fatality, she resided with her mother and had no siblings. In September 2017, when the family resided in Wayne County, the child was hospitalized for two months due to severe infections and unexplained injuries as well as what was considered non-accidental oral trauma. The child required several surgeries to address the concerns. The child was discharged to her mother from the hospital on 11/21/17. On 12/23/17, the child underwent an outpatient procedure, and was placed on an antibiotic. The child was in the third percentile of weight gain, but the mother was compliant with all medical treatment recommendations and the child was deemed otherwise healthy. As a result of the child's 2017 hospitalization for unexplained injuries, a full stay-away Order of Protection was issued against the father regarding the mother and child. It was discovered from 12/16/17 until the date of the fatal incident, the mother had initiated contact with the father and allowed him access to herself and the child on a regular basis.

On 1/1/18, the mother last saw the child alive at 7AM. The father had spent that weekend at the mother's home, and offered to care for the child that morning so the mother could sleep. The father reported while the mother went back to bed, he walked around the apartment with the child to settle her, and then laid her on her back on a "Boppy" pillow on the floor. The father sat beside her and watched television. Less than 15 minutes later, the father reported he looked at the child and saw she was blue in color, cold and limp. He attempted to give the child a bottle, and then briefly attempted CPR before waking the mother. The mother saw the child and immediately called 911. EMS responded to the home and brought the child to the hospital. The child was on life support from 1/1/18 until 1/3/18. Medical staff concluded the child was suffering from numerous life-threatening conditions, including a significant brain edema consistent with an anoxic injury. The doctors attributed the child's rapidly declining condition to non-accidental trauma. The child had no brain activity and was removed from life support. She was pronounced deceased at 2:40PM on 1/3/18.

From the time the investigation began to the time of this writing, MCDHS met with and interviewed both parents, family members, and spoke with some collateral sources. The home environment was assessed as safe. The 30-Day Fatality Report was not completed timely. MCDHS offered the mother appropriate services in response to the fatality. The father refused to engage with MCDHS after he was arrested for Criminal Contempt. Law enforcement did not file charges

against the mother. At the time of this writing, the investigation remained open and the mother had begun to engage in services.

PIP Requirement
MCDHS will submit Program Improvement Plans (PIP) to the Regional Office within 30 days of issuance of this report. These PIPs will identify what action(s) MCDHS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, MCDHS will review the plan(s) and revise as needed to further 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?** 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

Explain:
There were no surviving siblings. The investigation had not yet been determined at the time of this writing.

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:
The level of casework activity was commensurate with the case circumstances. The investigation remained open at the time of this writing.

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:	MCDHS did not complete the 30 Day Fatality Report until 7 days after the required due date.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The 30-day Fatality Report must be documented in a template in Connections within 30 days of the receipt of a report alleging the death of a child because of abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/03/2018 **Time of Death:** 02:40 PM

Date of fatal incident, if different than date of death: 01/01/2018
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: 08:13 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
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Unknown if they were 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	Mother	Alleged Perpetrator	Female	34 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	24 Year(s)

LDSS Response

On 1/1/18, an SCR fatality report was received regarding SC. At the time of this report, SC was found to still be alive, but her prognosis was extremely poor. On 1/3/18, another SCR fatality report was received regarding SC's death. MCDHS initiated the investigations within 24 hours and coordinated efforts with LE. It was determined there were no SS.

From 1/1/18 to 1/3/18, MCDHS met with SM, SF, and the maternal grandparents at the hospital in which SC had been admitted. MCDHS also spoke at length with LE and hospital staff regarding events leading up to SC's hospitalization and death. Through these interviews, it was learned SC had a prior hospitalization from 9/29/17 until 11/20/17: SC was

admitted due to having several serious infections in her body and bones which required surgeries. Throughout the duration of her stay, medical testing revealed SC had severe oral trauma, which caused breakage of teeth. The physicians at that time had made it clear that they felt the oral trauma was non-accidental; they could not say for sure if any other ailments were such. At the time of that hospitalization, the family lived in Wayne County, and WCDSS had been investigating reported concerns that the injuries SC sustained were inflicted, as well as concerns surrounding DV between SM and SF. WCDSS determined SM did not impose any injuries on SC; however, WCDSS documented they believed SF was responsible. A full stay-away Order of Protection (OP) was issued via Wayne County Family Court against SF regarding SC and SM, active from 12/11/17 until 6/11/18. Although LE was involved in the investigation, there were no criminal charges against SF at that time, and SM eventually moved to Monroe County.

Further interviews revealed from 12/16/17 to 1/1/18, SM allowed SF around herself and SC despite the OP. On the night of 12/31/17, SM said SC had been fussy and went to bed in her portable crib at 5PM. SM and SF then had several alcoholic beverages, and SF was intoxicated. SM fed SC at 10PM. SM went to bed around midnight, and SF around 2AM. SM fed SC again at 3AM and 7AM on 1/1/18. At that time, SF offered to care for SC so SM could sleep longer. SM stated 1 hour later, SF woke her and said there was something wrong with SC. SM found SC lying face up on the couch, blue and cold. SM called 911 and began CPR until EMS arrived. SM explained SC was on antibiotics due to medical procedure from 12/23/17, and SC last took the antibiotic at 7AM on 1/1/18. Aside from this and reported fussiness, SM said SC was happy and healthy.

On 1/3/18, MCDHS and LE interviewed SF. SF stated SC went in her crib at 7PM on 12/31/17, and then he and SM had several drinks. SF did not say what time he went to bed, but reported he awoke at 7AM and saw SM feeding SC. He said SM looked “really tired” so he offered to care for SC while SM slept for a few more hours. SM went back to bed and SF walked around with SC to settle her. SF then laid SC on a “Boppy” pillow face up on the floor beside him while he watched TV. SF said "13 minutes later" he looked over at SC and saw she was blue, cold and limp. SF said he laid her on the couch and tried to feed her a bottle; SC was making a “sniffing noise” for 3 minutes. SF then began CPR for 30 seconds before waking up SM. SF said SM saw SC and called 911.

Throughout the investigation, MCDHS spoke with collateral sources, including medical staff who noted SC was admitted in acute respiratory failure, and presented with encephalopathy, hypotension, coagulopathy, cerebral edema, and anoxic brain injury (acidosis). Medical documentation stated SC’s decompensation was consistent with “inflicted, non-accidental injury.” The autopsy results remained pending at the time of this writing. SF was charged with Criminal Contempt in the 2nd Degree; there were no charges against SM. MCHDS offered SM appropriate services. SF refused to cooperate with the investigation following the initial interview. MCDHS substantiated SM and SF for IG due to violation of the Order of Protection, but found they did not have evidence to substantiate the allegations of DOA/Fatality and II against SF. Although the allegations had been determined at the time of this writing, the investigation remained open pending finalization.

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
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
045861 - Deceased Child, Female, 9 Mons	045862 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
045861 - Deceased Child, Female, 9 Mons	045863 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
045861 - Deceased Child, Female, 9 Mons	045863 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
045861 - Deceased Child, Female, 9 Mons	045863 - Father, Male, 24 Year(s)	Internal Injuries	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?	☐	☒	☐	☐
Other	☐	☒	☐	☐
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 contacted collateral sources surrounding SC and her death. MCDHS attempted to contact SC's visiting nurse, but were not successful.

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?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Other - Criminal Contempt **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	SF	Unknown	Unknown
Comments:	SF was charged with Criminal Contempt in the 2nd in response to the death of SC.		

Have any Orders of Protection been issued? No

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 offered SM services in response to the fatality. SM did not utilize the referrals made by MCDHS for grief and

trauma services, but rather chose providers on her own accord in her community. Domestic violence services were also offered, but at the time of this writing, SM had yet to engage. SF was not cooperative during the investigation, and therefore appropriate services could not be offered.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS provided SM with referrals for services in response to the fatality, as well as to address ongoing DV concerns. SM also began to engage in other services in her community. SF was not cooperative with MCDHS for the majority of the investigation, and therefore, appropriate follow-up regarding possible service needs was unable to occur.

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? 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)	Status/Outcome	Compliance Issue(s)
09/30/2017	Deceased Child, Female, 6 Months	Father, Male, 24 Years	Internal Injuries	Indicated	Yes
	Deceased Child, Female, 6 Months	Father, Male, 24 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Deceased Child, Female, 6 Months	Mother, Female, 34 Years	Internal Injuries	Unfounded	

Deceased Child, Female, 6 Months	Mother, Female, 34 Years	Lacerations / Bruises / Welts	Unfounded
Deceased Child, Female, 6 Months	Father, Male, 24 Years	Inadequate Guardianship	Indicated
Deceased Child, Female, 6 Months	Father, Male, 24 Years	Lacerations / Bruises / Welts	Indicated
Deceased Child, Female, 6 Months	Mother, Female, 34 Years	Inadequate Guardianship	Unfounded

Report Summary:
Wayne County Department of Social Services (WCDSS) received a report with concerns the then 6-month-old SC had numerous serious and unexplained injuries, including: extensive oral trauma, scalp hematoma, bruises on her body, distended abdomen, sepsis, and respiratory distress. Since there was no explanation to the injuries, SM and SF were named subjects. There were further concerns SF had a history of violent behavior toward SM, and he assaulted her several times in the presence of SC. On 9/28/17, SF pushed SM and punched a wall.

Determination: Indicated | **Date of Determination:** 12/12/2017

Basis for Determination:
WCDSS based their decision to indicate the allegations against the SF, but not SM, due to SM reporting she felt SF had something to do with SC's injuries. WCDSS spoke at length with law enforcement and hospital staff regarding SC's condition throughout the investigation. SF obtained legal counsel and refused to speak with WCDSS. By the close of the investigation, SM had obtained an OP against SF, and SC had been released from the hospital to the SM's care. SM and SC moved to Monroe County prior to case closure.

OCFS Review Results:
The SCR history check was not conducted within 1 business day of receiving the report.

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

Issue:
Review of CPS History
Summary:
The SCR history check was not completed until the second business day.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, WCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Issue:
Case record contains information that is relevant, useful, factual and objective
Summary:
Progress notes throughout the investigation contained conflicting information regarding SM's need for services. A note entered by WCDSS on 10/25/17 documented answers to questions found in the RAP. WCDSS stated in this progress note the following: "Need for other services: No." It is clearly outlined in the case record, as well as this progress note, that SM was in need of several services at that time, especially in response to domestic violence concerns. It was not until the end of the investigation when SM moved to Monroe County that WCDSS asked the MCDHS caseworker to offer SM services.
Legal Reference:
18 NYCRR 428.1 (b)(1)
Action:

Local social services districts must provide a thorough family assessment and an account of all family and children's services delivered to children and their families through case records maintained in the form and manner and at such times as required by OCFS. Such records must contain information that is relevant, useful, factual and objective and contribute to the district's understanding of a child's or family's need for involvement with the child welfare system.

[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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: 12/11/2017	**To:** 06/12/0018
Explain: A full stay-away Order of Protection was issued on 12/11/17 against SF regarding SM and SC, after SC was found to have sustained non-accidental trauma to her mouth in September 2017.	

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