Child Fatality Report

Report Identification Number: BU-18-012

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

Issue Date: Sep 18, 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: 7 month(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 04/29/2018
Initial Date OCFS Notified: 05/02/2018

Presenting Information

An SCR report received on 5/1/18, alleged that on 4/29/18 the SM and SC were sleeping in bed and the SM awoke to find the SC deceased. The SM and SC were covered with blankets while they slept. The SC had no preexisting medical condition and was an otherwise healthy child.

Executive Summary

This report concerns the death of the 7-month-old female SC. Erie County Department of Social Services (ECDSS) received an SCR report regarding the SC's death on 5/1/18 and promptly began their investigation. The SC was an otherwise healthy child and had no preexisting medical condition. The SM and SC were staying in the home of the SM's friend (OA1) and OA1's mother (OA2) for the 3 weeks preceding the SC's death. The SC and SM previously resided in the state of Florida and left after they were displaced as a result of a natural disaster.

At approximately 4AM on 4/29/18, the SM and SC went to sleep in a full size bed. The SC was lying on her side and covered with a blanket. The SM woke at 12PM on 4/29/18 to change the SC's diaper, and found her face down in the mattress. The SC was blue in color, cold and unresponsive. Emergency services were called and EMS, LE and the fire department responded. They were unable to resuscitate the SC and therefore, she was not taken to the ER. The SM denied the SC had woken between the hours of 4AM and 12PM to eat, and stated they often went to sleep at this time and woke in the early afternoon.

The ME was notified and performed an autopsy. The ME reported the SC appeared to be well cared for and there were no signs of trauma to her body. The final autopsy report was not completed at the time this report was written, but the ME believed the cause of death was likely positional asphyxiation based on the SC's position at the time the SM discovered her. LE investigated the fatality and shared their interviews and findings with ECDSS. LE did not pursue criminal charges against the SM and concluded the SC's death was the result of the SM's poor judgment.

ECDSS made several visits to the homes of the SM's relatives and also to the home of OA1. ECDSS learned the SM had 4 other children (ages 10, 8, 6 and 3) that resided with other relatives due to previous MH and substance abuse issues of the SM. The 8yo and 6yo SS lived in another state with their paternal grandparents. ECDSS contacted the children's services division in that state and requested the safety of the children be assessed. The state performed a home visit and found the SS to be safe in the care of the PGM and PGF. ECDSS saw the 10yo SS at the MGF's home and learned the SS lived with the MGGM and was safe in her care. ECDSS saw the 3yo SS at her home and assessed her to be safe in the care of another MGGM. ECDSS learned the 10yo SS had sporadic contact with the SM and SC since their arrival in New York State. The MGGM monitored the 10yo and 3yo SS contact with the SM. The 8yo and 6yo SS had no contact with the SM and none of the SS had contact with their biological fathers.

ECDSS substantiated the allegations of DOA/Fatality and IG against the SM regarding the death of the SC. ECDSS based their determination on evidence gathered, including the SM co-sleeping with the SC and finding the SC lying face down in the mattress. The SM failed to exercise a minimum degree of care and ECDSS appropriately concluded the sleeping environment likely contributed to the SC's death.

Although the SM was minimally cooperative with ECDSS during the investigation, ECDSS was able to offer her support services. ECDSS gave the SM referrals for housing, financial assistance, mental health counseling, grief counseling, a

substance abuse evaluation and also assisted with burial assistance. The SM accepted the referral information, but it was unknown if she participated in any of these services.

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

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:
There were no surviving children in the care of the SM and it was appropriate to close the case.

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: 04/29/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 12:00 PM

County where fatality incident occurred: Erie

Was 911 or local emergency number called? Yes
Time of Call: 12:17 PM
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	73 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	51 Year(s)

LDSS Response

After receiving an SCR report regarding the death of the SC on 5/1/18, ECDSS initiated their investigation. ECDSS conducted a CPS history check and contacted the source, LE, ME and the DA. ECDSS learned the SM had four other children, none of which resided with her. ECDSS located and assessed the safety of each of the SS. The SS were not present in the home at the time of the fatality.

ECDSS coordinated their efforts with LE during the investigation and learned the SM and SC had been residing in the home of OA1 and OA2. LE and ECDSS spoke with everyone who was present in the home when the SM discovered the SC unresponsive in the afternoon of 4/29/18. The SM told LE she had moved back from Florida a few months ago and denied knowing who fathered the SC. The SM reported that she and the SC went to sleep at about 3AM on 4/29/18, in a full size bed. The SM positioned the SC on her side to sleep. The SM reported waking at 12PM on 4/29/18 to find the SC face down in the blanket and cold to the touch. The SM picked up the SC and carried her out of the bedroom, while yelling for help. The SM denied the SC woke during the night to eat. The SC admitted to drinking a "shot" of alcohol the evening prior to the SC's death, but denied any other drug use. The SM disclosed illicit drug use during her pregnancy with the SC and also disclosed mental health issues. The SM did not provide any further details other than the SC stopped breathing. The SM would not meet with ECDSS face-to-face, despite numerous attempts. The SM was minimally cooperative when

speaking with ECDSS, and it was not clear if the SM received safe sleep education.

ECDSS spoke with OA1 and learned he and the SM had been friends for 7 years. OA1 allowed the SM and SC to stay in his home temporarily. OA1 resided in the home with OA2 (his mother, whom he cared for). ECDSS observed the bedroom the SC and SM used in OA1's home. There was a full size bed in the room and no crib was observed. OA1 explained the SM and SC routinely stayed up late at night and slept in the following day. On 4/28/18, OA1 went to sleep between 10-11PM, and woke at 4AM on 4/29/18, to use the bathroom. At that time OA1 heard the SM and SC awake in their bedroom and he went back to bed. OA1 woke again at 8AM and had breakfast with OA2. At that time, the SM's bedroom door was closed and he assumed SM and SC were still asleep. OA1 stated OA3 (OA1's daughter and nursing aide to OA2) arrived at the home at 10AM and began to get OA2 ready for the day. At about 12PM on 4/29/18, the SM came out of the bedroom screaming that the SC was cold. OA3 called 911 and began performing CPR on the SC. OA1 reported EMS responded to the home and continued CPR. The SC was already deceased and was taken away by EMS. OA1 did not have any other information. OA2 had cognitive limitations and was unable to provide ECDSS with any details of the fatal incident. OA2 did confirm the SM and SC lived in the home and recalled EMS responding to the home. OA1 and OA2 denied any concerns regarding the SM's care for the SC. OA1 also denied the SM used drugs or alcohol.

ECDSS interviewed OA3 and she confirmed the details provided by OA1. OA3 denied any concern regarding the interactions she had previously observed between the SM and SC.

ECDSS contacted first responders and learned that OA3 was performing CPR when they arrived. The SC was cold and lifeless when they arrived and was taken to the ambulance, where she was pronounced deceased. The SC's nose was observed to be deformed as if she had been laying face down when she died.

ECDSS contacted a medical clinic in New York, where the SM reported she had taken the SC. The clinic reported there were 4 appointments scheduled for the SC in 12/17 and 1/18, and the SC did not attend any of them. The SC had never been seen there. ECDSS contacted CPS in the state of Florida to gather information on any history the SM and SC may have had there. There was no response noted in the case record.

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?No
Comments: ECDSS does not have an OCFS approved Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047501 - Deceased Child, Female, 7 Mons	047504 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
047501 - Deceased Child, Female, 7 Mons	047504 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated

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:

Although ECDSS made several attempts to locate and speak with the SM face to face, she was uncooperative in efforts to coordinate a meeting. ECDSS spoke with the SM over the telephone and she was interviewed.

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 safety 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.

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	☐	☐	☐	☐	☐	☒	☐

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? Yes
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)

06/26/2017	Sibling, Female, 2 Years	Grandparent, Female, 63 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report was received regarding the SS. The SS was in the custody of the MGGM. The report alleged there was a sex-offender frequenting the home, and at times the MGGM left the SS alone with the sex-offender.

Report Determination: Unfounded | **Date of Determination:** 07/26/2017

Basis for Determination:
OCDSS found the MGGM had custody of the SS for several months, after she was removed from the care of the SM. The man frequenting the home was the MGGM's partner and found to have no sexual criminal history. Collateral contacts were made with the pediatrician and daycare provider and no concerns were noted.

OCFS Review Results:
The casework was commensurate with the case circumstances.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/24/2016	Sibling, Female, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 1 Years	Other Adult - SM's partner, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the SM and then PS were involved in a violent altercation in the presence of the then 1-year-old SS. The SS was at risk of harm. The SM reported she no longer wanted to care for the SS, because the SS was deaf and the SM was overwhelmed.

Report Determination: Indicated | **Date of Determination:** 10/14/2016

Basis for Determination:
MCDSS confirmed the SM and then PS had an altercation in the presence of the SS. The SM was injured as a result of the incident and went to the ER with the SS. The SM was emotionally unstable while at the hospital and told staff she did not want to care for the SS anymore. The SS was removed from the SM's care and a plan was later made that the SS go to the home of the MGGM. The MGGM was awarded custody of the SS. The SM had no interest in completing services to regain custody of the SS.

OCFS Review Results:
Casework was commensurate with circumstances.

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

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

8/6/08-2/13/09-An SCR report with an allegation of IG Unsub against the SM of SS, regarding the SS.
1/26/09-4/15/09-An SCR report with an allegation of IG Unsub against the BF of the SS, regarding the SS.
7/31/09-9/24/09-An SCR report with an allegation of IG Unsub against the BF of the SS, regarding the SS.
3/8/10-3/31/10-An SCR report with allegations IG and PD/AM against the SM regarding the SS.
5/27/12-8/16/12-An SCR report with allegations of IG, LMC, and PD/AM Sub against the SM regarding the SS.
4/26/13-7/30/13-An SCR report with an allegation of IG Sub against the SM regarding the SS.

Known CPS History Outside of NYS

It could not be confirmed if there was history outside of New York State. ECDSS requested records from the state of Florida, where the SC was born and the SM and SC previously resided. The records were never received.

Preventive Services History

There was an open Preventive Services case from 8/14/12-12/19/13 involving the SM, BF of the eldest SS, and the 3 eldest SS. The case was opened as the result of an indicated CPS report and an Article 10 Family Court Petition filed by ECDSS. There were concerns about the safety of the 3 SS in the care of the SM, due to MH concerns, substance abuse and failure to seek appropriate and regular medical care for the children. The eldest SS went to live with his BF and the youngest 2 SS went to live with their PGM and PGF. Throughout the open case, ECDSS assisted the SM with linking into MH and substance abuse treatment and parenting classes. The SM did not successfully complete services and was uncooperative with ECDSS. The case closed as the SS were in the care of relatives that had custody of the children and they were deemed safe.

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

We at the Erie County Department of Social Services appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality or to the CPS investigations conducted during the three years preceding the fatality.

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