Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-17-023

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

Issue Date: Nov 22, 2017

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: 2 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 06/20/2017
Initial Date OCFS Notified: 06/20/2017

Presenting Information

On 6/20/17, at about 1:15PM, MGM put 2-year-old SC down for a nap in his crib. When SM arrived home from work at 3PM, she checked on SC and he was fine. When SM went back to check on SC again around 4PM, he was unconscious and had turned blue. SM then carried SC downstairs, laid him on the porch, and screamed for help. 911 was called immediately and the ambulance transported SC to the hospital. SC was not observed to have had any injuries, but vomit was coming out of his mouth. SC also had a seizure disorder. SC was pronounced deceased at the hospital.

Executive Summary

This fatality report concerns the death of a 2-year-old male (SC) that occurred on 6/20/17. A report was made to the SCR on that same date with allegations of DOA/Fatality and IG against SM and MGM regarding SC. Monroe County Department of Human Services (MCDHS) conducted an investigation surrounding SC's death. Neither a Death Certificate nor final autopsy report were available for review at the time of this writing; however, the ME reported SC appeared to have an infection that spread to his heart and through his body, which had just begun to present itself on the day of SC's passing.

It was discovered the night before SC's death, SC had a fever which SM and SF were treating with over-the-counter medications. On the morning of 6/20/17, SC was given another dose of medication before SM and SF left for work. While working, MGM was at the home caring for the SC and the 4-year-old SS. The SC was reported to have had a low-grade fever until approximately 1:30PM, but was otherwise acting normally. MGM last checked in on SC at approximately 3PM; SC was sleeping and appeared fine. SM returned home from work at approximately 3:30PM, and checked on SC at around 4:15PM. At that time, SM found SC unresponsive. Emergency services were called, and SC was transported to a local hospital, where he was pronounced deceased at 5:28PM.

SC was not reported to have had any pre-existing medical conditions; however, he did suffer a seizure in March 2017. This was the only documented seizure, and SC was an otherwise healthy child. No concerns were found regarding the home environment, the SS, the parents or MGM's ability to care for the children.

From the time the investigation began to the time of this writing, MCDHS met with all family members, and interviewed SM, SF, SS, and MGM. MCDHS also spoke with an array of collateral contacts, which included daycare providers, the pediatrician, hospital staff, LE, and the ME. MCDHS referred the family to grief and trauma services, which they ultimately declined. MCDHS found no evidence of abuse or maltreatment, and unfounded and closed the case.

Review of this investigation resulted in citations related to overall casework practices. In response, MCDHS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP 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 on-going concerns.

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 make all final assessments and determinations regarding this investigation.

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 casework was commensurate with the case circumstances. MCDHS's decision to unfound and close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	MCDHS did not provide Notices of Existence within the required 7 day timeframe (by 6/27/17). The letters were not given to the adults on the report until 7/11/17.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	Rochester Regional Office is aware of the above concern, and there is a plan in place that is outlined in MCDHS's current PIP to address such.
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, which was due 7/20/17, until 8/10/17.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	Rochester Regional Office is aware of the above concern, and there is a plan in place that is outlined in MCDHS's current PIP to address such.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/20/2017 **Time of Death:** 05:28 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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 45 Minutes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not 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	Male	2 Year(s)
Deceased Child's Household	Father	No Role	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	67 Year(s)

LDSS Response

On 6/20/17, MCDHS received an SCR report regarding the death of SC. MCDHS initiated their investigation within 24 hours, and coordinated their efforts with LE. MCDHS promptly followed up with the source of the report. MCDHS also spoke with an LE officer who responded to the case address, and the ER staff where SC was brought by ambulance. It was determined early on that there was no external evidence of any trauma to SC, and neither LE nor hospital staff had

concerns SC's death was caused by abuse or maltreatment. On the same date, MCDHS completed a home visit to assess the safety of the 4-year-old SS and the home environment; no concerns were noted. MCDHS offered SM and SF grief and trauma services, which they accepted at first, but then later declined. A CPS history review was conducted, and MCDHS requested the preliminary autopsy results from the ME.

During the investigation, MCDHS interviewed SF, SM, and SS in their home. At the initial home visit, MCHDS explained the CPS report and process to SM and SF. MCDHS gathered a timeline of events leading up to when the parents found SC unresponsive. It was reported SC had not been feeling well and had a fever the night prior to the incident. SM and SF had been giving SC over the counter medication every few hours to relieve SC's symptoms. SF stated he gave SC a dose of medication at approximately 5AM on 6/20/17, prior to leaving for work. SM was also at work that day, and MGM was at the home watching both children. It was discovered MGM gave SC one last dose of medication at approximately 11AM, and MGM called SF to inform him SC's fever broke shortly thereafter. SM reported she arrived home from work that day at approximately 3:30PM. She was informed by MGM that SC was asleep upstairs and seemed to be fine; MGM then left. SM spent time with SS, and went to check on SC at approximately 4:15PM. This is when SM found SC unresponsive. MCDHS did not ask any further questions at that time; however, per a conversation between LE and MCDHS on 6/20/17, after finding SC unresponsive, SM then ran outside with SC and a neighbor contacted 911. LE had also stated SM reported to them SC had a seizure the day he died, but MCDHS did not follow up with SM, SF, or MGM regarding this information.

MCDHS interviewed MGM and she reported SC did have a fever when she arrived at the home around 8:30AM the day of the incident, but he was "normal" and running around and playing. MGM corroborated she gave SC a dose of medication at approximately 11AM, and at around 12:30PM, laid him down for a nap. MGM stated she checked on him at approximately 1:30PM, and found he was no longer running a fever and was sleeping. MGM again checked on SC at 3PM, and found him to still be sleeping and he flinched when she touched him. MGM explained SM arrived home from work shortly afterward, and MGM then left.

MCDHS obtained hospital records and also spoke with SC's pediatrician. The pediatrician reported SC did not have a seizure disorder, but did suffer one seizure in March of this year. SC was seen by a neurologist, and there were no long-term effects or treatments needed; however, there was no guarantee more seizures would not occur in the future. MCDHS also spoke with LE, who reported the ME found SC had an infection that spread to his heart valves and the rest of his body, which just began presenting itself on the day of SC's passing. Despite this information, the final autopsy had not yet been completed by the time of this writing, and the manner and cause of death remained pending. MCDHS gathered sufficient information throughout their investigation and found no evidence to support the allegations in the report. The review found adequate supervision was provided to the CW; however, the 30 Day Fatality report was completed late, and the Notice of Existence letters were not provided to the family within the required timeframe. MCDHS appropriately unfounded and closed the case.

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 MDT.

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
041845 - Deceased Child, Male, 2 Year(s)	041846 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
041845 - Deceased Child, Male, 2 Year(s)	041847 - Grandparent, Female, 67 Year(s)	Inadequate Guardianship	Unsubstantiated
041845 - Deceased Child, Male, 2 Year(s)	041847 - Grandparent, Female, 67 Year(s)	DOA / Fatality	Unsubstantiated
041845 - Deceased Child, Male, 2 Year(s)	041846 - Mother, Female, 37 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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 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?	☐	☒	☐	☐

Explain as necessary:
The initial safety assessments were appropriate. The SS did not need to be removed as a result of this fatality or for other reasons unrelated.

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	Needed but 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:
Appropriate grief/trauma services were offered to the family, but they declined. MCDHS did not offer funeral assistance.

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:
MCDHS offered grief and trauma services to SM and SF for SS; however, the family chose to receive counseling services through a private practitioner.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
MCDHS offered grief and trauma services to SM, SF and MGM; however, all chose to receive counseling services through a private practitioner.

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?	No
Was the child acutely ill during the two weeks before death?	No

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 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.

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

This fatality report has been reviewed and it is factually correct.

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