Child Fatality Report

Report Identification Number: BU-18-006

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

Issue Date: Aug 01, 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: 10 month(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 02/27/2018
Initial Date OCFS Notified: 02/28/2018

Presenting Information

When the SC was 1 month old, she sustained bleeding on her brain, her toes and fingers turned blue, and she became unresponsive. At that time, the SC was in the care of the SF. The SC was taken to the hospital, where she suffered cardiac arrest, was revived, and placed on life support. The SC died on 2/27/18 as the result of the injuries she sustained in the SF's care. The SC had been previously hospitalized when she was 2 weeks old for discoloration of her extremities, and it was later suggested this was the result of intentional suffocation while in the care of the SM, SF or both. Before the SC's death, the SF physically assaulted the SM in the SC's hospital room while she was present.

Executive Summary

This report concerns the death of the 10-month-old female SC. Erie County Department of Social Services (ECDSS) had an open CPS investigation that began on 1/8/18 regarding the SM, SF and SC at the time of her death. ECDSS notified OCFS by completing a 7065 agency reporting form and later received an SCR report regarding the fatality on 3/7/18. The SC was born a healthy child with no complications and had been hospitalized on five separate dates since birth. The SM and SF had no explanation for the injuries that led to her hospitalizations. The SC died in the hospital on 2/27/18 where she had been inpatient since 9/7/17.

The ME performed an autopsy and the final report was not completed at the time of this writing. The ME reported that the SC's brain was abnormal due to an hypoxic injury, and the cause was unknown. The ME found the SC had broken ribs and one of her femurs was different from the other. The SC's eyes, rib cage and both femurs were sent for further testing. The testing did not reveal any concerns with the SC's eyes and the other tests remained pending. The ME reported no other abnormal findings and was also waiting on toxicology results.

LE was notified and jointly investigated with ECDSS. LE was unable to find evidence to bring forth criminal charges against either the SM or SF. The SM and SF both denied ever harming the SC accidentally or intentionally. The SM and SF disclosed previous instances of physical violence in their relationship, with the SF acting as the aggressor, and denied any impact to the SC.

ECDSS diligently worked to interview all possible sources of information to gather the facts surrounding the circumstances that led to the SC's multiple hospitalizations and ultimate death. All appropriate casework and collateral contacts were made. Medical staff had concerns that the SC may have been injured as the result of non-accidental trauma; however, ECDSS was not notified of the numerous unexplained injuries until the SC was 5 months old. By the time ECDSS first became involved, the SC had been in and out of the hospital five times and had been through several medical procedures. ECDSS was working on concluding the investigation at the time of this writing, but had not yet made a determination of the allegations.

ECDSS fully completed all casework activity in a timely fashion, commensurate with case circumstances. ECDSS offered bereavement services to the SM and SF and the SM was already engaged in counseling at the time of the SC's death. The SM continued seeing her therapist, but refused a referral for DV counseling. The SF declined services.

PIP Requirement

ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) ECDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ECDSS will review the plan and revise as needed to 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?** Unable to Determine

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 case 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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/27/2018 **Time of Death:** 04:33 PM

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

County where fatality incident occurred: Erie
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? Unable to determine

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	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

On 2/27/18, ECDSS received notification from hospital staff that the SC was deceased. ECDSS had an open investigation regarding the SC at the time of her death, and received an additional SCR report regarding the fatality on 3/7/18. ECDSS contacted LE, the DA and the ME promptly after they were notified of the SC's death. Neither the SM nor the SF had any other children and there were no surviving children in the SC's home.

Throughout the investigation, ECDSS contacted multiple collaterals, including doctors, EMS that previously responded to the SC's home, friends of the SM, and the MGM.

ECDSS learned the SC had multiple hospitalizations in the short time between her birth and death. ECDSS gathered information from interviews with the SM, SF and medical records to form a timeline of the SC's medical history preceding her demise. ECDSS reviewed medical records and learned the SC was hospitalized five times from the time of birth until her death. The SC final hospitalization was from 9/2017 until her death. At the time of the fatality the SC was in a vegetative state on life-sustaining medical equipment.

The ME also provided a timeline of the SC's hospitalizations leading up to her death based on her review of the medical records. During these hospitalizations the SC was treated for a choking incident, an hypoxic injury, hypothermia, seizure-like activity, and an acute hematoma. The ME enlisted the assistance of a forensic anthropologist to analyze a significant break on the SC's femur. The ME believed the fracture occurred at the hospital based on the timeline. The SC also had rib fractures, that may have been attributable to CPR efforts. Although the SC's injuries were suspicious, the ME could not definitively say that abuse caused her death.

LE and ECDSS jointly interviewed the SF and SM. They both denied causing any injuries to the SC. The SM and SF reported the SC had turned blue and stopped breathing at home on several occasions and this led to hospitalizations. During one of the hospitalizations, the SC became unresponsive after her breathing tube was removed. This event caused irreversible brain damage. The SM and SF reported the same details about the events leading up to the SC's hospitalizations, in addition to complications that occurred while she was hospitalized.

The SF had a history of physical aggression toward the SM. Both the SM and SF admitted this and minimized the violence in their relationship. Medical records revealed that in 12/2017, the SM told the hospital Social Worker she believed the SF was a "health risk" to the SC and requested his visits with the SC be restricted. ECDSS questioned the SM about that statement and the SM reported she did not want the SF's new paramour visiting her child and receiving medical information. She simultaneously denied any concerns for the safety for the SC while the SF visited, but SF's paramour had threatened her. The SM did not take legal action and the SF was permitted to see the SC. The SM and SF denied any alcohol or drug misuse.

The MGM and SM each reported that while the SC was at home, the SF would push on her chest and perform what was described as adult CPR, to resuscitate her while she was breathing. The SF denied performing CPR in that manner and described performing infant CPR only when the SC had stopped breathing. A friend of the SM's told ECDSS she believed the SF did something to injure the SC, because each time he was alone with the SC she experienced a medical emergency.

At the time this report was written, ECDSS had not yet concluded the investigation.

Official Manner and Cause of Death

Official Manner: Undetermined
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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046482 - Deceased Child, Female, 10 Mons	046484 - Father, Male, 22 Year(s)	Internal Injuries	Pending
046482 - Deceased Child, Female, 10 Mons	046484 - Father, Male, 22 Year(s)	Inadequate Guardianship	Pending
046482 - Deceased Child, Female, 10 Mons	046483 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Pending
046482 - Deceased Child, Female, 10 Mons	046484 - Father, Male, 22 Year(s)	DOA / Fatality	Pending

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:
The SC died while a patient in the hospital. She was under the medical care of a physician.

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? 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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:

☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/08/2018	Deceased Child, Female, 9 Months	Father, Male, 22 Years	Internal Injuries	Unsubstantiated	Yes
	Deceased Child, Female, 9 Months	Father, Male, 22 Years	Choking / Twisting / Shaking	Unsubstantiated	
	Deceased Child, Female, 9 Months	Father, Male, 22 Years	Inadequate Guardianship	Substantiated	

	Deceased Child, Female, 9 Months	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated

Report Summary:
An SCR report was received with allegations the SF was physically abusive to the SM throughout her pregnancy and after the birth of the SC. The SM was aware the SF was violent and not a suitable caregiver for the SC, yet she continued to allow him to care for her. There were several occasions where the SM left the SC alone with the SF and the SC suffered injuries and medical emergencies as a result. A subsequent SCR report was also received with allegations the SF assaulted the SM at the hospital in the presence of the SC. The subsequent report was merged with the 1/8/2018 report.

Report Determination: Indicated **Date of Determination:** 04/09/2018

Basis for Determination:
ECDSS found there was historically a suspicion of the SF perpetrating violence against the SM, both during her pregnancy and after the birth of the SC. The SM minimized the violence, and the SF denied any violent behavior against the SM. However, several collateral contacts confirmed the domestic violence. ECDSS found credible evidence that the SF exhibited violent behavior toward the SM in front of the SC. ECDSS did not find credible evidence regarding the allegations regarding the SF causing injury to the SC. Medical professionals were not able to definitively say what cause the injuries leading to the SC's multiple hospitalizations.

OCFS Review Results:
The SM and SF were interviewed. ECDSS contacted all appropriate collaterals and gathered pertinent information to make the determination. The casework was commensurate with the case circumstances.

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

Issue:
Failure to provide notice of report

Summary:
The SF and SM were not provided with a notice of existence for the subsequent SCR report that was received on 1/31/2018.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
ECDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/21/2017	Deceased Child, Female, 5 Months	Mother, Female, 22 Years	Internal Injuries	Unsubstantiated	Yes
	Deceased Child, Female, 5 Months	Father, Male, 23 Years	Internal Injuries	Unsubstantiated	
	Deceased Child, Female, 5 Months	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 5 Months	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received on this date, and alleged the SC (5 months old at the time) had bilateral subdural hematomas. There was no explanation as to how the SC sustained the injuries. The SC was in the care of the SM and SF when the injuries occurred and they were both named as subjects.

Report Determination: Unfounded	**Date of Determination:** 01/02/2018

Basis for Determination:
ECDSS found no credible evidence to support the allegations of IG and L/B/W against the SM and SF regarding the SC. The SC had been admitted to the hospital several times before ECDSS was notified. At the time the report was received the child's current hospitalization had begun 3 weeks prior. The SC appeared to have suffered a head injury, and medical providers had conflicting opinions about the cause of the injuries. LE was involved but no criminal charges were brought forth. ECDSS consulted with their legal department, but there was no evidence to move forward with neglect. The SC had a poor prognosis and was to be discharged home with comfort care.

OCFS Review Results:
ECDSS contacted the source and LE upon receiving the SCR report. ECDSS assessed the SC was safe in the first 24 hours, as she was hospitalized. ECDSS learned the SC was born a healthy child but had been in and out of the hospital since birth. ECDSS spoke with medical professionals and some expressed concerns that the injuries to the SC were non-accidental. However, none of the doctors were willing to give a statement concluding the SM or SF caused the injuries to the SC. ECDSS reviewed medical records and SC had no signs she was shaken. A medical cause could not be ruled out. The SM and SF denied harming the SC.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The investigation began on 9/21/17 and the 7-day safety assessment was approved on 10/2/17.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Within seven days of receiving a report, ECDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm. ECDSS will compete a safety assessment in Connections within 7-days to document the assessment.

Issue:
Failure to provide notice of report
Summary:
The SCR report was received on 9/21/17 and the notice of existence was sent on 12/20/17.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ECDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

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

There is no CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

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

ECDSS is pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality at this time. With respect to the preceding investigation dated 9/21/17, we recognize that we did not complete the 7-day safety assessment in the regulatory time frame. Namely, the safety assessment was due by 9/28/17 but was not submitted until 9/29/17 and was not approved until 10/2/17. In response to a similar compliance issue, an agenda item was recently added to a CPS Team Leader (TL) meeting on 6/12/18 to remind supervisors of the statutory requirement that the 7-day safety assessment must be completed and approved within the first 7 days of receipt of an SCR report. The TLs were instructed to review these requirements with their CPS workers and to ensure that each unit and worker has an effective means of tracking safety assessment due dates.

With respect to the preceding SCR reports dated 9/21/17 and 1/8/18, we recognize that the Notices of Existence (NOEs) were not sent to the father or mother in a timely manner for the 9/21/17 report and were not sent at all for a 1/31/18 subsequent report attached to the 1/8/18 initial report. We have recently taken several steps to address the issue of timely delivery of NOEs. In a CPS TL meeting held on 3/13/18, the need for the timely issuance of NOEs (i.e. within 7 days of receipt of an SCR report) was addressed with all CPS TLs. The TLs were instructed to review this requirement with their CPS workers. In a memo sent to all Erie CPS staff on 3/16/18, staff was reminded that NOEs must be hand-delivered or mailed within 7 days of receipt of an SCR report. Finally, the CPS Report Review and Documentation Checklist utilized by ECDSS to ensure that all required tasks have been completed in a CPS investigation was augmented on 5/8/18 as follows: the field that previously read “NOEs sent” (yes or no) was changed to read “NOEs sent within 7 days of report” (yes or no).

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