Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-19-006

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

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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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 02/06/2019
Initial Date OCFS Notified: 02/06/2019

Presenting Information

On 2/6/19, an SCR report was received. The report stated earlier in the afternoon the father was the sole caretaker for the subject child. At 3:00PM the father put the infant down for a nap, at about 5:30 the father fed the infant and put him back to sleep. At about 6:00PM the mother arrived home and found the infant unresponsive, face down on an adult-sized bed with blankets. He had blood and white froth in his mouth when he was found. EMS transported the infant to the ER and he was pronounced deceased. The subject child had no known preexisting medical conditions and was an otherwise healthy child, which made his sudden death suspicious. The mother had an unknown role in the incident.

Executive Summary

This report concerns the death of the 5-month-old male child. Monroe County Department of Human Services (MCDHS) received an SCR report regarding the infant's death on 2/6/19. The infant had no known medical condition or illness and was an otherwise healthy child. The circumstances of the death were considered suspicious. The mother was not in the home at the time of the incident, the father was the sole caretaker for the infant. The infant was the only child of both the mother and father, and there were no other children residing in the home.

On the morning of 2/6/19, the mother was at work, while the father was home alone with the infant. The father fed the infant and placed him on an adult sized bed to sleep. The father checked on the infant three times in about a 3 hour time frame and found the infant still asleep. When the mother arrived home the father and mother found the infant lying face down in the bed and unresponsive. There were blankets and pillows on the bed, but the parents denied these items were on or near the infant. Emergency services were contacted and responded to the home. Life saving measures were performed by EMS and the infant was transported to the ER. The infant did not survive and his death was pronounced at the hospital.

The ME performed an autopsy and the manner and cause of death were pending further investigation at the time of this writing. The ME's preliminary report showed no signs of trauma or injury to the infant.

LE extracted the data from both the mother's and father's phones and reported no concerns. LE's investigation found no evidence to suggest any criminality surrounding the infant's death, and expressed it was likely attributable to medical issues or an unsafe sleep environment. LE was no longer actively investigating at the time of this writing; they were keeping the case open pending the final autopsy results.

MCDHS spoke with multiple collateral contacts throughout their investigation, including relatives, MH providers for the parents and first responders. MCDHS also requested and reviewed photos of the home provided by LE, 911 calls and medical records.

MCDHS appropriately substantiated the allegation of IG against the father, based on his failure to exercise a minimum degree of care when placing the infant to sleep on a queen size mattress with pillows and blankets. The environment was unsafe for the infant and he was found lying face down on the mattress. MCDHS unsubstantiated the allegation of DOA/Fatality against the father as they had no evidence the unsafe sleep environment was the cause of the infant's death. There were no allegations against the mother because she was not present at the time of the incident.

Immediately after the infant's death, the father expressed suicidal ideations and was subsequently hospitalized. Upon his

discharge from the hospital, the father relocated to another state where he had the support of family members. MCDHS provided the mother with a family victim advocate and offered her bereavement counseling. The mother accepted the assistance of the victim advocate and declined the counseling services. The mother had a counselor that she regularly saw and she continued her treatment after the death of the infant.

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?** 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 pertinent information and had contact with all relevant collateral sources of information.

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:
MCDHS gathered sufficient information to make a determination of the allegations, 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: 02/06/2019 **Time of Death:** 06:39 PM

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

Child Fatality Report

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? 1 Hours
At time of incident supervisor was:

- ☐ Drug Impaired
- ☒ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	Male	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	No Role	Female	24 Year(s)

LDSS Response

On 2/6/19, MCDHS received a report regarding the death of the infant. MCDHS initiated their investigation within 24 hours, in coordination with LE. MCDHS contacted the source, did a CPS history check for the family and contacted the ME. MCDHS learned there were no surviving siblings or other children residing in the infant's home.

MCDHS went to the home with LE. MCDHS interviewed the father regarding the events of 2/6/19. He reported he arrived home from work at 9:25AM and slept for a bit, while the infant was napping. The mother left for work at around 11:00AM. A plumber arrived at the home around 12:00PM and the infant remained asleep. The father said at about 2:45PM the infant woke up and he brought him into the living room and fed him. The father then brought the infant into the bedroom and laid him on the queen size bed, positioned on his side with his bottle. The father sat on the bed with the infant for a bit and was on his phone. The father disclosed arguing with the mother on the phone and also talking to several relatives. He reported the infant was able to roll, and move on his belly. At some point the father left the room and returned to check on the child 3 times. The first time was about 3:40PM, and he was still positioned on his side. At sometime after 4:00PM he checked on the infant again and he was still asleep. The third time he checked on the infant he was lying on his stomach, with his face positioned to the side. The next time the infant was seen was after the mother arrived home. At that time he was lying on his stomach with his face down in the mattress. The father reported the infant's back was hard and he

was lifeless. The father called 911 and denied hurting the infant.

MCDHS went to the ER to speak with the mother. The MGM was also present. The mother expressed she felt that the father did something to the infant, although there was no evidence to verify her suspicion. She stated the father had untreated MH issues and at times did not act appropriately in conversations with her or when caring for the infant. She said that she had been on the telephone with the father while she was at work on 2/6/19 and they were arguing. During one of the calls at 3:42PM, she heard the infant crying in the background and she told the father to tend to him and they could continue their conversation when she arrived home from work. The mother arrived home around 6:00PM and said the father jumped up off the couch and ran into the bedroom where the infant was sleeping. The mother followed him in the bedroom and found the infant face down on the bed. The father picked him up and his arm flopped down, alerting her something was wrong. She took the infant from the father and ran to a neighbor's home to call 911.

The mother and father denied any drug use in front on the infant, but the father admitted to occasional marijuana and alcohol use. The parents received safe sleep education, and owned a portable crib and bassinet, but admitted routinely placing the infant in the bed to sleep, positioned on his back.

MCDHS reviewed the 911 calls relating to the incident and learned both the neighbor and father had called 911. MCDHS spoke to first responders and they reported the mother and father gave them the same information as was provided to MCDHS. The pediatrician had no concerns for care of the infant, but he had been discharged from their care in August of 2018. MCDHS attempted to contact several medical providers who reportedly treated the infant, but found no records for him.

MCDHS spoke with the plumber that was at the home on 2/6/19. He confirmed he was there from 12:00PM until 3:00PM. The father told the plumber he and the mother were not getting along. The plumber confirmed the infant was sleeping when he arrived at the home and he woke before the left, as he heard him crying. He reported the father appropriately attended to the infant.

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?Yes
Comments: The fatality was referred for review to the OCFS approved Child Fatality Review Team in Monroe County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050064 - Deceased Child, Male, 6 Mons	050066 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
050064 - Deceased Child, Male, 6 Mons	050066 - Father, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated

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CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

MCDHS spoke with the pediatrician that initially saw the infant after his birth and learned his care was transferred to another pediatric practice in September of 2018. MCDHS was unable to locate that pediatrician and speak with the doctor.

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Family Victim Advocate							

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? N/A
Explain:
There were no surviving siblings or other children living in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was referred to a Family Advocate and for MH counseling, but disclosed she already had a counselor. The father was hospitalized immediately after the fatality due to suicidal ideations. When the father was discharged from the hospital he left New York State to reside with family members.

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

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ 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

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 investigative 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.

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 draft fatality report was reviewed by Monroe County. We are in agreement with the facts as presented.

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