Child Fatality Report

Report Identification Number: RO-20-028

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

Issue Date: Jun 01, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 14 day(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 12/08/2020
Initial Date OCFS Notified: 12/08/2020

Presenting Information

On 12/8/2020, Monroe County Department of Human Services (MCDHS) received an SCR report which alleged that on 12/8/2020, the mother (SM) found the 2-week-old subject child (SC) unresponsive in his bassinet. The mother called 911 and initiated CPR until EMS arrived. The child was transported to the hospital and pronounced dead following his arrival. There were three surviving siblings in the home, ages 6, 5, and 3 years old. A subsequent report was made which alleged the child had bruising to his face at the time of his death.

Executive Summary

This report concerns the death of a 2-week-old child which occurred while in the care of his mother. MCDHS received the SCR report on 12/8/2020 and coordinated their investigation with law enforcement.

MCDHS conducted familial interviews with the mother and surviving siblings. The child was in the special pediatric unit following his birth for breathing issues and hypoglycemia, and was discharged a week prior to his death. On the night of his death, the mother said she fed the child a bottle, which he mostly spit up, and put him to sleep in his bassinet at approximately 11:00 PM. There were some items at the foot of the bassinet, such as clean diapers, wipes, and a bottle. The mother woke up around 1:45 AM and found the child unresponsive and called 911. The child was transported by EMS to the hospital where he was pronounced dead at 2:45 AM. The safety of the three surviving siblings was assessed throughout the investigation and they were determined to be safe in the care of the mother.

Hospital records showed that the mother expressed concerns for the child's breathing and a follow up appointment was made with the pediatrician following discharge home. At the time of his death, the child showed no signs of trauma, despite reports to MCDHS of bruising to his head.

MCDHS conducted the investigation in accordance with regulatory requirements. The final autopsy was pending at the time the investigation was closed and there was no determination the child's death was due to an unsafe sleep environment or a medical condition. The mother was engaged with bereavement services and there were no criminal charges going to be pressed. The allegations against the mother of DOA/Fatality, Inadequate Guardianship, and Lacerations, Bruises, Welts were unsubstantiated.

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:
MCDHS made a determination of the allegations in accordance with the evidence gathered.

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: 12/08/2020 **Time of Death:** 02:45 AM

Time of fatal incident, if different than time of death: 01:45 AM

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 01:46 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 165 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted
☒ Asleep
☐ Absent
☐ 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	14 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Other Adult - BF to 5 and 3 SSs	No Role	Male	26 Year(s)
Other Household 2	Other Adult - BF to 6-year-old SS	No Role	Male	41 Year(s)
Other Household 3	Father	No Role	Male	27 Year(s)

LDSS Response

MCDHS received the SCR report, coordinated their response with LE and notified the district attorney. LE responded to the home and observed that baby supplies such as diapers, wipes, and bottles were in the bassinet where the SC had been sleeping. LE and MCDHS conducted initial interviews at the hospital. The hospital staff informed MCDHS and LE that the SC had spent time in the pediatric unit following his birth due to breathing and blood sugar issues. The SC was discharged from the hospital a week prior to his death. The time of death was 2:45 AM. There were no signs of trauma to the SC, and medical providers identified that any bruising or discoloration could be attributed to life saving interventions or lividity.

The SM was interviewed and stated the SC had been fed a bottle at approximately 11:00 PM on 12/7/20, and spit much of it up. The SM noted the SC was breathing heavily, and she placed him to sleep in the bassinet. The SM stated she then went to sleep and awoke at approximately 1:45 AM and found the SC unresponsive. She called 911 and initiated CPR as instructed. The SM confirmed that she had expressed concerns about the SC's breathing since he was born. The SM said the SC tested negative for COVID-19 upon his birth. The SM stated she brought the breathing concerns up with the pediatrician and she wanted another COVID-19 test to be administered; however, the pediatrician stated there were no concerns with the SC's breathing. The SM stated the SC slept in his bassinet and confirmed some supplies were kept at his feet for easy access in the night. MCDHS offered the SM services which included financial assistance with the burial and bereavement counseling.

A home visit was conducted the night of the SC's death with LE. The home was observed to be unkempt, however free of health and safety hazards. No other beds for the SSs were observed and the SM reported the children slept on the couches. MCDHS coordinated with a service provider to deliver beds to the home for the SSs.

The SSs were interviewed while in the care of a babysitter. The SSs confirmed that the SC regularly slept in the bassinet and identified little to no knowledge of the fatal incident.

Hospital records were obtained for the birth and death of the SC. The records showed that the SC was kept in the pediatric unit due to breathing complications and being hypoglycemic. The record noted the SM's concerns for the SC's breathing patterns and follow up with the pediatrician was to occur following discharge. The records showed that at the time of his death, the SC showed no signs of trauma.

Pediatric records were obtained and noted no concerns for the SC. The pediatric records showed no concerns for the SC's breathing during his visit.

MCDHS made multiple unsuccessful attempts to reach the BF of the SC. The SM stated that the BF had not met the SC prior to his death and provided MCDHS with known contact information to aid in attempts to reach him.

MCDHS contacted the two biological fathers to the SSs. There were no concerns identified for the SSs and they expressed no knowledge of the fatal incident.

MCDHS conducted their investigation in accordance with regulatory requirements. The final autopsy was pending at the time the investigation was closed. The preliminary results showed no signs of trauma, and no criminal charges were being pressed by LE. It was unclear at the time the investigation closed if the death was related to unsafe sleep or a medical condition. The allegations against the SM of DOA/Fatality, Inadequate Guardianship, and Lacerations, Bruises, Welts were unsubstantiated. The SM was engaged with bereavement counseling at the time the investigation closed and there were no safety concerns for the SSs in the care of the SM.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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: MDCHS coordinated their response with an MDT approach.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: Monroe County has an approved OCFS Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057061 - Deceased Child, Male, 14 Days	057062 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
057061 - Deceased Child, Male, 14 Days	057062 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
057061 - Deceased Child, Male, 14 Days	057062 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	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?	☒	☐	☐	☐
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 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	☒	☐	☐	☐
Explain: Risk was assessed throughout the investigation and services were offered in relation to the child's death.				

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.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☒	☐	☐	☐	☐	☐	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐

Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Services were offered and accepted by the mother which included bereavement, funeral assistance, and obtaining new beds for the SSs.

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:
Services were offered and declined by the SM.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM was offered and accepted bereavement counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
☐ 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)
01/02/2019	Sibling, Male, 4 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The report alleged that the SM had failed to follow through with necessary steps to ensure housing for herself, the 4-year-old SS, the 3-year-old SS, and the 1-year-old SS. The family would be homeless as of 1/3/2019 and would have to live out of their car.

Report Determination: Unfounded **Date of Determination:** 02/10/2019

Basis for Determination:
MCDHS interviewed familial and relevant collateral contacts. It was determined that although the SM did not take all necessary steps to ensure housing, the SM made a plan to stay with a relative until housing could be secured. MCDHS made a referral to a local agency to provide assistance with obtaining furniture and the home was furnished and free of health and safety hazards upon case closure.

OCFS Review Results:
MCDHS met regulatory requirements while investigating the allegations. Prior to MCDHS involvement, the SM had made a plan to stay with a relative. The SM had secured a new apartment within a few days and services were offered to assist the SM in obtaining furniture for the new apartment. No immediate concerns for the health and safety of the SSs were identified through collateral contacts and the investigation was closed.

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

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

There was 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 NYS.

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

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