



Report Identification Number: RO-18-022

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

Issue Date: Dec 05, 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: 4 month(s)

Jurisdiction: Monroe
Gender: Male

Date of Death: 06/25/2018
Initial Date OCFS Notified: 06/25/2018

Presenting Information

An SCR report was received on 6/25/18 that alleged the father put the 4-month-old child in his crib for a nap at 1:00PM. The father checked on the child at 1:30PM and found him face down, blue and unresponsive. The child was taken to the hospital and pronounced deceased. The child had no bruises or injuries and was an otherwise healthy child. The mother was at work at the time of the incident and it was unknown if the grandparents were home. All other adults in the home had an unknown role.

Executive Summary

This report concerns the death of the 4-month-old male subject child. Monroe County Department of Human Services (MCDHS) received an SCR report regarding the fatality on 6/25/18. The SC was an otherwise healthy child and there was no explanation as to his sudden death. The baby was in the care of his father at the time of his passing and therefore he was the alleged subject of the SCR report.

On the morning of 6/25/18 the grandmother woke with the baby, then fed and changed him before leaving for work. The mother and grandfather were already at work at that time and the father was home alone caring for the infant. The father placed the child face down on a pillow inside his crib for a nap. The father left the room for a period of about a half hour and returned to find the baby unresponsive. The father contacted 911 and EMS responded. The baby could not be resuscitated and his death was pronounced at the hospital.

The infant had no siblings, but there was a 17yo maternal uncle residing in his home. The uncle was interviewed and assessed to be safe. MCDHS contacted the uncle's school and learned they had no concerns regarding his attendance, grades or behavior.

The ME was notified and performed an autopsy. The preliminary summary report from the ME stated the baby's cause and manner of death were pending further investigation. The autopsy report had not been received by MCDHS at the time this report was written.

LE jointly investigated the infant's death, with MCDHS. LE found no evidence that the death was the result of a criminal act.

MCDHS gathered pertinent medical records, interviewed everyone residing in the infant's home and spoke with appropriate collaterals to fully assess the totality of the family dynamics. MCDHS completed fatality reports and safety assessments in a timely manner and entered progress notes contemporaneously.

MCDHS learned that the mother and father received safe sleep education and the parents believed they were practicing safe sleep methods. The allegations IG were substantiated against the father because there were several items present in the crib that were identified as aggravating factors in the baby's sleep environment, causing it to be unsafe. MCDHS determined that the presence of the aggravating factors in combination with the baby's age and developmental limitations were evidence that the father placed the child in immediate danger of serious harm. The allegation of DOA/Fatality was unsubstantiated because MCDHS did not find credible evidence that the death was due to the father's failure to provide a minimum degree of care to the infant. There was no medical evidence provided to suggest the father inflicted or allowed to be inflicted a serious physical injury to the child that resulted in his death.



MCDHS offered the family trauma intervention services; however the family declined. The father was offered a referral for a substance abuse evaluation, but he declined. MCDHS also provided the family with referrals for grief counseling services and support. It was unknown if the family pursued the services.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
 - **Approved Initial Safety Assessment?** Yes
 - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

The casework was commensurate with the case circumstances.

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:

It was appropriate to conclude the investigation.

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: 06/25/2018

Time of Death: Unknown

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

01:15 PM

County where fatality incident occurred:

Monroe

Was 911 or local emergency number called?

Yes

Time of Call:

01:30 PM

Did EMS respond to the scene?

Yes

At time of incident leading to death, had child used alcohol or drugs?

No

Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes

How long before incident was the child last seen by caretaker? 30 Minutes

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	Aunt/Uncle	No Role	Female	18 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	17 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	46 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	45 Year(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)

LDSS Response

MCDHS began their investigation after receiving notice of the infant's death on 6/25/18. MCDHS contacted the source, ME and coordinated their investigation with LE. A CPS history check was performed and MCDHS found the family had no CPS history. The infant was healthy, took no medication, and had no surviving siblings.

MCDHS spoke with the grandparents, the 17yo maternal uncle, and the parents at the hospital. The uncle was the only other child in the home and was assessed to be safe. The uncle said he was home the morning of 6/25/18, and left at about



12:00PM to go to work. He said the father was caring for the infant that day as he normally did, because the father worked overnights, while the mother worked day hours. When the uncle left the home, the infant was fine. The aunt was out of the country at the time of the baby's death, but MCDHS spoke to her when she returned. The aunt reported everyone in the home got along well and denied any concerns for the care her nephew was provided.

The mother said she was at work at the time of the infant's death and had no concerns for the father caring for him. The mother reported the child slept either in his crib or in a "Rock and Play" in the grandparent's room. The mother received safe sleep education and said the child was never placed to sleep in the bed or on his stomach. The mother did say the child was regularly placed to sleep either on his back, side or on his "chest" on the "Boppy" pillow. The baby was only placed on the pillow for naps during the day, when there was constant supervision.

The grandfather told MCDHS he left the home at 8:00AM on 6/25/18 to go to work and the infant was asleep at that time. The grandmother stated the infant slept in her bedroom the evening of 6/24/18 and she woke with him at 6:30AM and fed him a bottle. At 9:30AM the grandmother said she changed the SC and then she left for work. When she left the home the infant was on her bed, lying on his back, and the father was playing with him. The grandparents denied any concerns for the father's care of the baby.

MCDHS spoke with the father and he confirmed he was the only family member home at the time of the fatal incident. He stated he had left the home at 8:30AM to take a test for a new job and when he returned home the grandmother left to go to work. He also said the uncle was home until about noon. After the uncle left, the father took the infant into his bedroom and played with him on the bed for awhile. The father gave the child a little bit of peanut butter for the first time, but the child had no adverse reaction. At about 12:45PM, the father put the child on his chest in the crib on top of a "Boppy" pillow. The father stated the baby liked that position. The father also placed a pacifier in the infant's mouth. He then went into the kitchen to make a sandwich and watched a video on his phone. About a half hour later, the father checked on the baby and found him in the same position and not breathing. The father began CPR but was not confident he was performing it properly; he then called 911.

The father admitted to occasional recreational marijuana use, but stated he did not use when he was the sole caregiver for the infant. MCDHS noted the father did not appear to be impaired at any time during their interaction with him. He reported he received safe sleep education at the hospital when the baby was born.

The first responders and ER staff reported the father was consistent in his reporting of the events leading up to the baby's death. The child did not have any injuries and was not found to have had an allergic reaction as the result of the peanut butter he was given. MCDHS spoke with the pediatrician and learned the baby was taken for regular visits and he had no concerns.

LE reported the crib contained the "Boppy" pillow, 3 crib bumpers, a small baby pillow, a nursing towel, a baby blanket and a pacifier. There was also a larger comforter hung on the outside of the crib.

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



SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048327 - Deceased Child, Male, 4 Month(s)	048332 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
048327 - Deceased Child, Male, 4 Month(s)	048332 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:

The parents, grandparents, aunt and uncle were all offered trauma and grief counseling services. The grandmother and parents expressed interest in the services, but it is unknown if they followed through with the referrals. The father was offered a substance abuse evaluation and declined these services. He stated his marijuana use was recreational and not a problem.

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? N/A
- 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

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 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

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