Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-21-023

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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 8 month(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 10/11/2021
Initial Date OCFS Notified: 10/11/2021

Presenting Information

An SCR report was received which alleged that on 10/11/21, the mother woke up around 5:00AM while the eight-month-old subject child was asleep in his crib, and gave him a blanket to soothe his crying. The subject child settled down after being provided the blanket and the mother went back to sleep. At approximately 9:00AM, when the mother went to check on the child, she found him unresponsive, cold to the touch, and the blanket was in the child's mouth. The maternal grandmother called 911 and began cardiopulmonary resuscitation. The subject child was transported to the hospital via ambulance, and was pronounced dead due to unsafe sleeping conditions.

Executive Summary

This fatality report concerns the death of an eight-month-old male subject child that occurred on 10/11/21. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother. Monroe County Department of Human Services (MCDHS) received the report and investigated the child's death. An autopsy was performed; however, the final report had not yet been issued at the time of this writing.

At the time of the child's death, he resided with his mother, maternal grandmother, a maternal aunt and an adult cousin. There were no surviving siblings or other children in the home. The father resided elsewhere and had occasional visits with the child. The investigation revealed that at approximately 10:00PM on 10/10/21, the mother placed the subject child in a portable crib to sleep. The crib contained two fleece blankets, a teething ring, and a pregnancy pillow. The child was fussy and used one of the fleece blankets to soothe himself. The mother shared the room with the child, and the bed was beside the portable crib. The mother eventually fell asleep and was awakened by the child around 5:00AM on 10/11/21. The mother fed the child a bottle, and then placed the child back in the portable crib. The mother and child again fell asleep, and the mother next awoke at approximately 9:00AM. The mother checked on the child and found he was purple in color and unresponsive, with part of a fleece blanket in his mouth and down his throat. The mother yelled for the maternal grandmother to help, and emergency services were called. The child was transported to the local hospital where he was pronounced deceased at 10:05AM.

MCDHS spoke with family members and collateral sources including law enforcement, the child's pediatrician, first responders and hospital staff. There were no criminal charges brought against the mother regarding the death of the child, and the law enforcement investigation remained open pending the final autopsy. MCDHS found some credible evidence to substantiate the allegation of Inadequate Guardianship due to the mother providing the child with blankets in his bassinet; however, the medical examiner was unable to provide a medical causal link between the child's death and the sleeping environment, as the final autopsy report had not yet been completed. MCDHS indicated and closed the investigation.

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 sufficient information to appropriately determine the allegations. There were no surviving siblings or other children in the household.

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

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: 10/11/2021 **Time of Death:** 10:05 AM

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 09:35 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? 4 Hours
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	Aunt/Uncle	No Role	Female	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	8 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Other Adult - Cousin	No Role	Female	19 Year(s)
Other Household 1	Father	No Role	Male	20 Year(s)

LDSS Response

On 10/11/21, MCDHS and LE interviewed SM. SM stated over the past 2 days, SC had a fever from teething, and gave him acetaminophen as needed. SM said SC had been fussy and not sleeping or eating well. SM stated MGM cared for SC on 10/10/21 until 10:00PM, then SM brought SC back upstairs to the room they shared. SM said she put SC to sleep in his portable crib with a fleece baby blanket. There was also another fleece blanket and a pregnancy pillow in the crib. SM said she knew she was not supposed to have any objects in SC's sleeping environment. SM reported she and SC fell asleep, and SM awoke around 5:00AM to feed SC. SM then put SC back in his crib and both went back to sleep. SM said when she awoke around 9:00AM and checked on SC, he was purple and one of the fleece blankets was in his mouth and partially down his throat. SM reported she did not know how the blanket got so far back in his throat, and although SC did tend to put things in his mouth, she had never seen him do so with blankets.

On this same date, MCDHS accompanied LE to the family's address to observe the home. SM and SC's room was upstairs, while the rest of the family's rooms were downstairs. MCDHS noted a portable crib next to SM's bed, and inside were two fleece blankets, a pacifier and a teething ring. The record did not note a pregnancy pillow was observed. The room was cluttered, but provisions for SC were noted. At the time of this home visit, MA was present and interviewed by MCDHS. MA stated she and MGM would often help care for SC, as SM appeared to become overwhelmed and upset with SC easily. MA denied that SM would ever intentionally harm SC. MA explained that she and MGM used marijuana daily, but not in the presence of SC. MA also reported MGM drank occasionally and expressed mental health concerns for both MGM and SM. MA denied that SM used drugs or alcohol. MCDHS noted no safety hazards in the home.

On 10/12/21, MCDHS spoke with MGM, who denied having any recent concerns surrounding SC. MGM explained that she helped often with SC's care. The record did not reflect that MCDHS asked MGM any questions surrounding events leading up to the fatality. MCDHS also spoke with BF on this date. He reported no concerns regarding the care SM provided to SC and explained he had not seen SC since 10/6/21. BF would not provide any further information.

On 10/18/21, MCDHS received the LE report regarding the fatality, which clarified a timeline of events. The report noted SM was awake with SC in her room until around 3:00AM on 10/11/21. SC slept until 5:00AM, and then SM gave him a bottle. She then returned SC to the crib and gave him the fleece blanket. SM then watched videos on her phone for 1 hour in a different part of the house before returning to her bedroom and going to bed. The report noted that SC appeared to still be asleep at that time. SM awoke after 9:00AM and when she checked on SC, she found him with the blanket in his mouth, not breathing. The LE statement further noted MGM last saw SC alive around 1:00AM on 10/11/21 and denied hearing anything unusual until SM began screaming for help.

It was revealed that BF had occasional contact with SC, and he had a history of hitting and verbally abusing SM over several years. Another maternal aunt and a cousin who lived in the home were also interviewed and had no concerns surrounding SC. Their recollection of events corroborated those reported by SM, OA and MGM. All household members expressed having mental health concerns for one another. MCDHS provided the family with referrals for counseling services as well as DV services for SM. Collateral sources did not disclose any safety concerns, and pediatric records noted SM was educated surrounding safe sleep practices on several occasions. LE found no criminality regarding the death of SC. MCDHS found evidence to support the allegation of IG, but did not find a causal link to substantiate for DOA/Fatality. The case was indicated and close.

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: This fatality investigation was conducted by the Monroe County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was referred to the Monroe County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059870 - Deceased Child, Male, 8 Mons	059871 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
059870 - Deceased Child, Male, 8 Mons	059871 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐

All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
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 interviewed the family and appropriate collateral sources; however, did not speak with the ME to see if SM's explanation of SC's death was plausible. Progress notes and other documentation were completed and entered timely.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
MCDHS provided the parents and other family members with referrals for counseling services and information regarding funeral cost assistance.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS provided the mother and other family members referrals for grief counseling following the fatality.

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? 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 was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was 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