Report Identification Number: RO-22-027

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

Issue Date: Feb 13, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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 **Jurisdiction:** Monroe **Date of Death:** 09/04/2022
Age: 1 month(s) **Gender:** Male **Initial Date OCFS Notified:** 09/04/2022

Presenting Information

On 9/4/2022, Monroe County Department of Human Services (MCDHS) received an SCR report regarding the death of the 1-month-old subject child. The subject child had been fed and placed in his bed to sleep by the mother and father. About 30 minutes later, the mother and father found the child was not breathing and called 911. EMS responded to the home, initiated CPR, and transported the subject child to the hospital where he was later pronounced deceased. The family was residing in an apartment with an adult roommate (other adult) and her 5-year-old child (other child).

Executive Summary

This report regards the death of the 1-month-old subject child which occurred on 9/4/2022. At the time of his death, the child resided with his mother and father, as well as the other adult and the other child.

Around 10:00 AM on 9/4/22, the subject child was crying. The mother fed the child and placed him to sleep on his side in a bassinet located in the parent's bedroom. At the time, the father was sleeping in an adult bed in the same room. About 2 hours later, the father woke and observed the subject child was not breathing. The father woke the mother and the other adult, who told the parents to call 911. EMS, law enforcement, and the fire department responded to the home. Upon their arrival, law enforcement noted the subject child's bassinet was folded up and not in use; however, the parents reported they had moved and folded the bassinet to make room for first responders due to a lack of space in the home. The subject child was transported to the hospital where he was pronounced deceased at 1:31 PM.

The parents were questioned about safe sleep practices and reported they would place the subject child to sleep in his bassinet. The parents denied they would co-sleep with the subject child. The parents stated they would regularly place the subject child to sleep on his side and reported the subject child's pediatrician told them it was safe to do so.

MCDHS learned from hospital staff that a skeletal survey was completed for the subject child and there were new rib fractures found; however, those injuries were believed to be the result of CPR and other lifesaving efforts. There were no further injuries or concerns noted during the skeletal survey.

MCDHS learned from law enforcement that an autopsy had been performed and there were no suspicions or concerns for abuse or neglect found regarding the death. The record did not reflect who was responsible for declaring the cause and manner of death, nor was there documentation that an autopsy report or death certificate were requested.

The case was closed 10/25/2022 and the allegations of Inadequate Guardianship and DOA / Fatality were unsubstantiated against the mother and father regarding the subject child. The case record noted there was not a fair preponderance of evidence to show that the subject child's death was caused by an unsafe sleeping situation.

During the initial home visit, there were concerns for the physical state of the home being a safety hazard for the other child. The home was noted to be cluttered and messy with clothing, old food, and other debris strewn about. There were multiple cats in the home that had fleas. There was also limited food in the home. A safety plan was made, and the other child stayed with a relative until the other adult made improvements to the home. The home was re-assessed as safe, and the other child returned home.

The record did not reflect fatality-related services were provided to the mother or father. The father requested such services, stating he was the person who discovered the subject child unresponsive. The record noted the parents were not eligible for the Family Trauma Intervention Protocol as they had no surviving children; nor could services be provided to the father, as he was a minor and any services would need to be approved by his parents. Services unrelated to the fatality were provided to the other adult and the other child.

PIP Requirement
MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS 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:**
  - **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?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
The record reflected missed opportunities to provide fatality-related services to the mother and father and MCDHS also missed opportunities to gather information from collaterals relevant to the fatality.

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: 09/04/2022 **Time of Death:** 01:31 PM

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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Other Adult - Other Adult	No Role	Female	24 Year(s)
Deceased Child's Household	Other Child - Other Child	No Role	Female	5 Year(s)

LDSS Response

MCDHS initiated an investigation immediately upon receiving the SCR report on 9/4/2022. MCDHS interviewed the mother and father as well as the other adult. Collateral contact was made with law enforcement, hospital staff, the pediatricians of the subject child and other child, the paternal grandmother, and the mother of the other adult.

The mother and father were interviewed separately. Both parents reported the subject child was their only child and stated the subject child was in good health and was up to date with pediatric well visits. The parents reported they would regularly put the subject child to sleep on his side and were instructed to do so by the child's pediatrician; however, MCDHS spoke with the subject child's pediatrician who reported parents were always advised on proper safe sleep procedures, including that their children should be put to sleep on their backs.

The other adult was interviewed and reported no specific safety concerns for the mother and father's care of the subject child. The other adult stated the parents did sometimes put the subject child to sleep in their adult bed with them; however,

she was unsure where the subject child was placed to sleep on the morning of the fatal incident. An attempt was made to interview the other child; however she was found to be non-verbal.

The home was found to be physically unsafe during the initial home visit, and a safety plan was made that the other child would stay with her maternal grandmother until such time as the other adult could make improvements to mitigate the safety concerns in the home. Subsequent home visits were conducted and the home was deemed appropriate, after which the other child was able to return home to the care of the other adult. MCDHS further provided services to the other adult to make improvements to the home, including the purchase of new appliances to replace those that were in disrepair.

The case record reflected that the parents moved out of the other adult's home prior to case closure. The mother moved in with the maternal grandmother, and the father moved into the home of his maternal grandmother.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062488 - Deceased Child, Male, 1 Mons	062489 - Mother, Female, 18 Year(s)	DOA / Fatality	Unsubstantiated
062488 - Deceased Child, Male, 1 Mons	062489 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
062488 - Deceased Child, Male, 1 Mons	062490 - Father, Male, 16 Year(s)	DOA / Fatality	Unsubstantiated
062488 - Deceased Child, Male, 1 Mons	062490 - Father, Male, 16 Year(s)	Inadequate Guardianship	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:

The other child was not interviewed as she was non-verbal.

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:
Service needs were identified for the mother and the father; however, no services were documented to have been provided to either parent.

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
Safety concerns were noted during the initial home visit, and a safety plan was enacted for the other child to stay with a relative until the safety concerns could be mitigated.

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: Preventive Services

Additional information, if necessary:
MCDHS did not offer or provide services to the parents related to the fatality. Preventive Services were offered to the other adult, but were declined.

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 fatality-related service needs identified for the other child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother and father stated they would be receptive to bereavement services following the death of the subject child. The record did not reflect any services provided or offered to the parents.

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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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)
08/17/2022	Other Child - Other Child, Female, 5 Years	Other Adult - Other Adult, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Other Child, Female, 5 Years	Other Adult - Other Adult, Female, 24 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SCR report alleged the other adult had been recommended, for the past 2 years, to have the other child evaluated for services as the other child was autistic; however, the other adult had not sought those services. The report further alleged the other child was disheveled, had poor hygiene, and wore soiled clothing.

Report Determination: Unfounded | **Date of Determination:** 11/03/2022

Basis for Determination:
The allegations of Inadequate Guardianship and Lack of Medical Care were unsubstantiated against the other adult regarding the other child. The investigation determination noted the other child was referred to a developmental pediatrician in July of 2021 and the other adult had difficulty scheduling that appointment, eventually submitting the required paperwork in October of 2022.

OCFS Review Results:
MCDHS found concerns for the physical state of the home which rose to the level that a safety plan needed to be made. The other child left the home to stay with a relative while the other adult made improvements. The other child later returned to the home. MCDHS contacted collaterals as appropriate and offered preventive services to the other adult, which were declined. MCDHS provided referrals to, and coordinated with, community agencies to help get new appliances for the family.

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

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
The case record for the fatality investigation, which overlapped significantly with the 8/17/2022 investigation, included information regarding the state of the home being a safety concern for the other child; however, information related to the state of the home, the safety plan made pursuant to that concern, and other relevant details were missing from the 8/17/2022 case record.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
MCDHS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/10/2021	Other Child - Other Child, Female, 4 Years	Other Adult - Other Adult, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Other Child, Female, 4 Years	Other Adult - Other Adult, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SCR report alleged the other adult had mental health issues, was suicidal, and had harmed herself while she was the

the sole caretaker for the other child. The report also alleged the other adult was an alcoholic.

Report Determination: Unfounded	**Date of Determination:** 05/10/2022

Basis for Determination:
The investigation determination noted the other adult and the grandmother of the other child both denied any suicidal ideation or self-harm for the other adult. The other adult and the grandmother of the other child also denied the other adult was an alcoholic and denied any issues for the other adult drinking while the sole caretaker for the other child. The determination noted there was no evidence found that the other adult's mental health had affected her ability to care for the other child.

OCFS Review Results:
There was a gap in contact with the family from 12/10/2021 to 5/2/2022, during which the only casework documented was phone and fax contact with the other child's pediatrician. Contact with the pediatrician on 1/20/2022 showed the other adult had been recommended to seek services for the other child at the local school district. On 5/2/2022 that the other adult reported she had contacted the school district; however, MCDHS did not verify with the school district or make referrals for other services. The other adult reported struggling with depression and being medicated for such; however, the record did not reflect a conversation with the other adult's prescribing medical provider.

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

Issue:
Failure to provide notice of report
Summary:
MCDHS learned the maternal grandmother of the other child was residing in the home; however, the maternal grandmother was not provided written notice of the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDHS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
MCDHS had no contact with the family from 12/10/2021 to 5/2/2022 and there was no casework activity from 1/20/2022 to 5/2/2022.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
MCDHS must continue to gather information to reassess safety of the child, throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static.(CPS Manual Chapter 6 section D page D-1 and D page D3.)

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The report alleged the other adult was suicidal and other adult reported she was struggling with depression and was prescribed medication for such by her primary care physician; however, the record did not reflect any contact with, or information gathered from, that prescribing doctor.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:

MCDHS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

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