Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-22-032

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

Issue Date: Jan 31, 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
Age: 2 month(s)
Jurisdiction: Wayne
Gender: Female
Date of Death: 10/12/2022
Initial Date OCFS Notified: 10/12/2022

Presenting Information

Wayne County Department of Social Services (WCDSS) received an SCR report on 10/12/22, which alleged on the same day, the mother was sleeping in bed with the 2-month-old subject child. The mother woke up and discovered the infant was cold and unresponsive. The mother called 911. Emergency medical services arrived at the home. The infant was transported to the hospital by ambulance where she was pronounced deceased at 1:41PM. The infant was an otherwise healthy child, and the mother did not have an explanation for her death.

Executive Summary

This report concerns the death of the 2-month-old female subject child. The report included allegations of Inadequate Guardianship and DOA/Fatality against the mother regarding the subject child. At the time of the child's death, she resided with her mother and father. There were no siblings.

On 10/11/22, the mother, father, and subject child co-slept in the same bed. The father woke up with the subject child around 5:00AM on the morning of 10/12/22 and fed her. The father and subject child went back to sleep in the bed. Prior to leaving for work at 7:30AM, the father changed the child's diaper, and then placed the child back in bed with the mother. When the father left the house, the mother and child were asleep. The mother and subject child woke around 11:00AM, and the child appeared to be well at this time. The mother fed the child a bottle and went back to sleep, placing the child in bed with her, on her back, with a blanket tucked around her. The mother remained in bed as well and went back to sleep. When the mother woke at 1:00PM, the child was unresponsive. The mother called 911 and attempted CPR. Emergency medical services arrived at the home and took over life-saving efforts. The child was transported to the hospital via ambulance. Life-saving efforts continued at the hospital; however, there were no changes and no signs of life. The child was pronounced deceased at 1:41PM.

The medical examiner performed an autopsy. The cause and manner of death were pending at the time the CPS investigation was closed. Law enforcement closed their investigation pending the autopsy and no criminal charges were anticipated.

WCDSS completed required home visits, interviewed the parents, and collateral contacts present the day of the fatal event.

During the investigation, WCDSS added and substantiated the allegations of Inadequate Guardianship and DOA/Fatality against the father regarding the subject child and substantiated all allegations against the mother. WCDSS found that the parents regularly co-slept with the child. Additionally, the mother was on medications she reported "sometimes knock me out" and described being more tired than usual. The father was aware of the medication the mother was taking and that they sometimes made her tired. Collateral contact with emergency medical services revealed it was believed the child was unconscious longer than when 911 was originally called, which supported the mother's statement of being "knocked out" and made her incapable of recognizing when the child was in distress. WCDSS concluded it was clear to the father that the mother was asleep in the bed when he placed the child in the bed with the mother and left for work. The family had a crib and pack and play available for use but failed to use them. WCDSS determined that a reasonably prudent parent would not consistently co-sleep with an infant under those circumstances.

WCDSS offered referrals to bereavement service. The mother was engaged in counseling services prior to the CPS case closing. The father was originally receptive to referrals; however, did not engage in bereavement services.

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:
There were no other children residing in the home. The subject child was the parents' only child, therefore, safety assessments were not required.

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 family was provided with bereavement and counseling resources. No further service needs were identified, and as there were no surviving children, the CPS investigation was closed upon the completion of all regulatory requirements.

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: 10/12/2022 **Time of Death:** 01:41 PM

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

County where fatality incident occurred: Wayne

Was 911 or local emergency number called? Yes

Time of Call: 01:05 PM

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A

Child's activity at time of incident:

- ☒ 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	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)

LDSS Response

WCDSS initiated their investigation within 24 hours and coordinated their efforts with LE. WCDSS contacted the source of the report, completed a CPS history check regarding the family, and notified the DA.

WCDSS interviewed the parents separately regarding the events leading up to SC's death. The family co-slept the night prior to the death. SF woke with SC around 5:00AM, fed SC, and they both fell back asleep. At an unknown time, SF woke and got ready for work. SF changed SC's diaper and placed SC back in bed with SM, who was asleep. SF then left for work around 7:30AM and at the time he left, SC and SM were asleep in bed together. SM woke around 11:00AM and fed SC a bottle. SM then fell back asleep in bed with SC. The next time SM woke around 1:00PM, the SM found SC blue in color and unresponsive. SM showed WCDSS the bed and described the sleeping arrangements. The bed was low to the ground, with sheets, two pillows, and two blankets observed. SM stated SC was on the right side and SM was in the middle of the mattress. At the time of the fatal incident, only the pillows were on the bed and SM described SC having a little blanket tucked around her and that SC was on her back. SM reported when she woke and found SC unresponsive, SC was still on the bed and on her back. Upon finding SC unresponsive, SM first ran upstairs to the neighbors, then called 911. 911 provided directions on how to perform CPR. EMS arrived and took over CPR. EMS reported they did not observe mottling, lividity, or rigor mortis at arrival, although SC appeared gray in color. Resuscitation efforts were continued in transport and sodium bicarbonate was administered to reverse acidosis. Upon arrival at the hospital, SC was in cardiac arrest and life-saving efforts continued. SC remained in asystole and pulseless. SC was declared deceased at 1:41PM.

WCDSS observed the home and found SC had access to a crib and pack and play; however, both sleeping environments contained multiple items placed within them. When asked about knowledge of safe sleep recommendations, SF denied the hospital provided the education and SM stated she could not recall. WCDSS provided information regarding safe sleep practices. WCDSS learned the pediatrician was unaware SM was co-sleeping with SC; however, noted they did have conversations with the parents about SC sleeping on her back.

It was learned SC was born prematurely, with neonatal abstinence syndrome, received morphine at birth, and SM was a

carrier for cystic fibrosis. WCDSS learned SM had a history of misusing prescription medication; however, she was engaged and compliant with treatment prior to the SC being born and at the time of the death. SM was prescribed medication to assist her in maintaining sobriety and addressing her mental health. Despite SC being born with intrauterine drug exposure to this medication, the record did not reflect that the SM misused her prescription medication during pregnancy or after the SC was born. There were no immediate concerns for SC from the pediatrician. SC was referred to homecare health services at birth due to neonatal abstinence syndrome. SC received services from 7/25/22 to 8/15/22, at which point she no longer scored on the neonatal abstinence syndrome scale, she was gaining weight appropriately, the parents were assessed to be willing and able to participate in the SC's care, so the SC was discharged.

WCDSS contacted numerous relevant collaterals, including LE, ME, EMS, and medical providers. Discussions with family collaterals revealed no concerns regarding the care of SC with the parents. Bereavement services were offered to the parents and SM was engaged in counseling prior to the CPS case closing. SF declined bereavement services.

WCDSS substantiated the allegations against both parents. The CPS case was closed as there were no surviving children in the home and no additional service needs identified.

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Wayne County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061901 - Deceased Child, Female, 2 Mons	061902 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
061901 - Deceased Child, Female, 2 Mons	061902 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
061901 - Deceased Child, Female, 2 Mons	061903 - Father, Male, 32 Year(s)	DOA / Fatality	Substantiated
061901 - Deceased Child, Female, 2 Mons	061903 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was engaged in mental health counseling prior to the investigation closing. The father was referred to counseling; however, decided he did not want to engage in counseling and was not engaged in any services prior to the investigation closing.

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

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

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