Child Fatality Report

Report Identification Number: RO-24-002

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

Issue Date: Jun 10, 2024

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:** 01/30/2024
Age: 1 year(s) **Gender:** Female **Initial Date OCFS Notified:** 01/30/2024

Presenting Information

An SCR report was received and alleged on 01/30/24, the 1-year-old subject child was at home in the care of the subject father. The subject father laid down on a couch and placed the subject child on his chest while the child was still awake. The subject father fell asleep at an unknown time with the child lying on his chest and when he awoke, he found the subject child unresponsive. The subject father did not have access to a phone and sought assistance from an individual outside the home. The individual called 911 and started CPR. While doing CPR, the individual found a bag in subject child's mouth which contained an unknown drug. The individual removed the bag and continued CPR until the emergency medical services arrived. The subject child was transported to the hospital where she was pronounced deceased at 12:31PM. The subject father had no explanation for the child's death. The subject mother was aware that the father was a drug user and not an appropriate caretaker.

Executive Summary

This report concerns the death of a 1-year-old female child that occurred on 1/30/24. On 1/30/24, Monroe County Department of Human Services (MCDHS) received two SCR reports regarding the fatal incident. The initial SCR report contained allegations of Inadequate Guardianship and Internal Injuries, against the subject father regarding the subject child. A subsequent SCR report was received on that same date and contained the allegation of Inadequate Guardianship against the mother and father regarding the subject child. In addition, the allegation of DOA/Fatality was listed against the father. MCDHS added the allegation of Inadequate Guardianship against the mother and father regarding the surviving sibling. Regarding the subject child, the allegation of Lack of Supervision was added against both parents and allegations of Parents Drugs/ Alcohol Misuse and Poisoning/ Noxious Substance were added against the father.

At the time of her death, the subject child resided with her mother and putative father. The 1-year-old twin surviving sibling resided with the maternal grandmother. There was an 11-year-old half-sibling who resided with her mother and had not had contact with the father in over a year. MCDHS immediately initiated their investigation and assessed the surviving sibling to be safe in the care of his maternal grandmother. MCDHS communicated with the biological mother of the 11-year-old half-sibling and learned she had never met the surviving sibling or subject child and assessed her to be safe in her mother's care.

MCDHS learned in the morning on 1/30/24, the mother left for work around 6:30AM and left the subject child in the care of her father. The father and child took a nap for approximately an hour on the couch. The father put the child on his chest and when he woke, the child was still in that position. The father attempted to wake the child, he lifted her up and noted her head "flopped" backwards and he immediately knew something was wrong. The father did not have the ability to make phone calls and flagged down two individuals in the apartment complex. One of the individuals contacted 911 while the other attempted CPR. Emergency medical services arrived and continued life-saving efforts while the subject child was transported to the hospital. Shortly after arrival to the hospital the subject child was pronounced deceased at 12:31PM.

MCDHS communicated with the medical examiner and learned a preliminary forensic evaluation was completed and showed the subject child tested positive for fentanyl and cocaine. At the time this report was written, the final autopsy report was still pending. MCDHS communicated with law enforcement and learned the father was indicted for Manslaughter in the Second Degree and Tampering with Physical Evidence. It appeared there were no criminal charges filed against the mother and the criminal proceedings were pending against the father.

MCDHS accurately substantiated the above referenced allegations against the mother and father; however, unsubstantiated Internal Injuries which was appropriate. MCDHS immediately initiated their investigation, spoke to the source of the reports, and completed a CPS history review. The 24-hour and 30-day fatality reports were completed timely. The safety assessments were completed timely and accurately. The Risk assessment Profile was completed accurately and consistent with case circumstances. MCDHS communicated with sufficient collaterals, entered progress notes contemporaneously and provided all required notifications.

MCDHS provided resources to the mother in relation to the fatality and gave a stuffed animal to the surviving sibling. In addition, resources were offered to the mother of the 11-year-old half-sibling but were declined. Burial assistance was provided by the mother's church. The CPS investigation was closed on 2/23/24 and opened for court-ordered services which remained open at the time this report was written.

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:
MCDHS made an appropriate decision to substantiate the allegations based on evidence obtained throughout their investigation.

Was the decision to close the case appropriate?	N/A
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:
Casework activity was commensurate with 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: 01/30/2024 **Time of Death:** 12:31 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: 11:52 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Yes
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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)

LDSS Response

Upon receipt of the SCR report on 1/30/24, MCDHS initiated their investigation within 24 hours, coordinated their efforts with law enforcement, and corresponded with the district attorney and medical examiner regarding the fatality. MCDHS immediately assessed the surviving sibling and implemented a safety plan that the sibling would remain in the care of the maternal grandmother.

On 1/30/24, MCDHS interviewed the father at the hospital and observed law enforcement's interview at their public safety building. During his interviews, he explained he awoke at 5:30AM and started the mother’s car because she had to work. The father stayed home to care for the subject child. Sometime after he awoke, the father admitted to using an entire

“baggie” of heroin. He reported using in the bathroom and described the color of the wax paper that was holding the heroin was blue. The father reported the child was fine in the morning, he fed her, and took a nap on the couch with the child laying on his chest. Around 11:00AM, the father woke with the child still laying on his chest, when he stood up the child’s head “flopped” backwards, and he observed her lips to be blue. The father was unable to make phone calls, so he ran outside the apartment and flagged down two maintenance workers. One of the maintenance workers contacted 911 while the other attempted CPR. While attempting CPR, a blue paper was found in the child’s mouth. The father later confirmed he believed the blue paper that was in the child’s mouth was the wax paper that contained heroin. The father admitted to using heroin daily and denied being in any form of substance abuse treatment.

On 1/30/24, MCDHS interviewed the mother at the hospital with law enforcement. During her interview, she explained she woke at 4:00AM, got ready for work and told the father to warm a bottle of milk. The mother observed the subject child looking at her and smiling when she left the residence at 6:30AM. The mother confirmed the father could not make phone calls but could receive text messages. The mother texted the father at 10:17AM and there was no response. The subject mother explained she received several calls from unknown numbers telling her something happened to the subject child and to go to the hospital. When asked about the father’s drug use, the mother confirmed the father uses daily and he has been using heroin for a couple years. The mother reported the father sniffs the drugs and denied knowing where they are kept but confirmed they come in “blue baggies”. The mother acknowledged she was aware of the father's drug use and that he had previous overdoses in 2022 and 2023, but denied he used in front of the children.

MCDHS communicated with law enforcement and learned that the subject father was found to have drugs on his person. The drugs were in his wallet and matched the description of the paper that was found in the child’s mouth. In addition, MCDHS and law enforcement observed the residence and found numerous blue wax papers littered throughout the home and that every room in the residence had some sort of drug or drug paraphernalia. Many of the items found in the residence were accessible to the children.

On 2/6/24 MCDHS filed Article 10 Severe Abuse petitions against the mother and father. MCDHS asked for the removal of the surviving sibling and for him to be placed in the care of his maternal grandmother under supervision of the department. Both parents consented to the removal and the child was ordered to be placed with his maternal grandmother. At the time this report was written, family court proceedings were on going.

MCDHS communicated with numerous collaterals throughout their investigation which included, the maternal grandmother, emergency medical services, hospital staff, law enforcement, daycare and the children’s pediatrician. At the time this report was written, the family was receiving court-ordered services.

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? Yes
Comments: Monroe County Department of Human Services has an OCFS approved Child Fatality Reiew Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
067408 - Deceased Child, Female, 1 Year(s)	067409 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
067408 - Deceased Child, Female, 1 Year(s)	067409 - Mother, Female, 31 Year(s)	Lack of Supervision	Substantiated
067408 - Deceased Child, Female, 1 Year(s)	067410 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
067408 - Deceased Child, Female, 1 Year(s)	067410 - Father, Male, 32 Year(s)	Lack of Supervision	Substantiated
067408 - Deceased Child, Female, 1 Year(s)	067410 - Father, Male, 32 Year(s)	DOA / Fatality	Substantiated
067408 - Deceased Child, Female, 1 Year(s)	067410 - Father, Male, 32 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
067408 - Deceased Child, Female, 1 Year(s)	067410 - Father, Male, 32 Year(s)	Poisoning / Noxious Substances	Substantiated
067408 - Deceased Child, Female, 1 Year(s)	067410 - Father, Male, 32 Year(s)	Internal Injuries	Unsubstantiated
067411 - Sibling, Male, 1 Year(s)	067409 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
067411 - Sibling, Male, 1 Year(s)	067410 - 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?	☒	☐	☐	☐

Additional information:

The 1-year-old sibling was unable to be interviewed due to his age and development.

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:
Appropriate services were offered in this case.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
MCDHS filed severe abuse petitions against the mother and father regarding the 1-year-old surviving sibling. The sibling was placed with his maternal grandmother, under the supervision of the department.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/06/2024	There was not a fact finding	There was not a disposition
Respondent:	067409 Mother Female 31 Year(s)	
Comments:	MCDHS filed Article 10 Severe Abuse petitions against the mother and father. The 1-year-old surviving sibling was removed and placed with his maternal grandmother under the supervision of the department.	

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Father	Pending	Pending
Comments:	The father was charged with Manslaughter in the Second Degree in relation to the fatality.		

Criminal Charge: Other - Tampering with Physical Evidence **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Father	Unknown	Pending
Comments:	The father was charged with Tampering with Physical Evidence in relation to the fatality.		

Have any Orders of Protection been issued? Yes	
From: 02/06/2024	**To:** Unknown

Explain:
The record reflected there were orders of protection against the mother and father in relation to the fatality.

Services Provided to the Family in Response to the Fatality

Services	Provided After	Offered, but	Offered, Unknown	Not Offered	Needed but	N/A	CDR Lead to

	Death	Refused	if Used		Unavailable		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? Yes
Explain:
MCDHS provided resources to the mother in relation to the fatality and gave a stuffed animal to the surviving sibling. There was an open Family Service Stage (FSS), and the family was receiving court-ordered services at the time this report was written.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS provided resources to the mother in relation to the fatality. In addition, resources were offered to the mother of the 11-year-old half-sibling but were declined. There was an open Family Service Stage (FSS), and the family was receiving court-ordered services at the time this report was written.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was the child acutely ill during the two weeks before death?	No

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