Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-22-019

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

Issue Date: Dec 19, 2022

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	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: 1 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 07/12/2022
Initial Date OCFS Notified: 07/12/2022

Presenting Information

On 7/8/2022, Monroe County Department of Human Services (MCDHS) received 4 SCR reports which alleged the 1-year-old child was found unresponsive in his crib by the father. The father and mother transported the child to an urgent care and the child was further transported to the hospital. A subsequent SCR report was received by MCDHS on 7/12/2022, after the child was pronounced deceased, and alleged the child had been found to have subdural and retinal hemorrhaging. The mother and father had not been able to provide any explanation as to how the child may have sustained those injuries. There were no surviving siblings or other children residing in the home.

Executive Summary

This report regards the death of the 1-year-old subject child which occurred on 7/12/2022. At the time of the death, the child resided with his mother and father in a room the parents rented from an unrelated adult. There were no surviving siblings and no other children residing in the home.

The child had been “fussier than normal” after eating his lunch on 7/8/2022, and the father placed the child down for a nap “to cry it out,” before going outside to sit in the car and use marijuana with the mother. The child was left inside the home unsupervised. After about 30 minutes, the father returned to the home to check on the child and found him sleeping. The father again left the home to spend time outside with the mother and did not return until about 90 minutes later around 3:00 PM, at which time he found the child unresponsive.

Around 4:00 PM, the parents drove the child to a local urgent care center that was not staffed or equipped to provide the necessary care to the child while he was in distress, and urgent care staff called 911. Emergency medical services and law enforcement arrived at the urgent care center, gathered information from the mother and father, and the child was transported to the hospital.

Hospital records noted the child suffered from multiple serious injuries including subdural hematoma, retinal hemorrhaging, and traumatic brain injury. Multiple medical providers, including a child abuse specialist, reported suspicion that the injuries suffered by the child were caused by non-accidental trauma.

Upon initial questioning by law enforcement and medical staff, the mother and father reported no trauma or injury to the child and stated they had no knowledge of any incident that could have led to the child becoming unresponsive. Later, when confronted with the seriousness of the child’s injuries, the father reported the child may have fallen from a chair in the kitchen; however, medical staff determined a fall of that nature would not have caused the child’s injuries.

The subject child was intubated in the emergency department and his condition did not improve. Due to his poor prognosis, the mother, in consultation with hospital staff, made the decision to remove the child from life support systems on 7/11/2022. The child was pronounced deceased at 12:08 AM on 7/12/2022.

An autopsy was completed and MCDHS spoke with the medical examiner; however, the cause and manner of death were pending as of the writing of this report. The criminal investigation remained open pending the results of the final autopsy report; however, no charges or arrests had been made as of the closure of the CPS investigation.

The SCR reported allegations of Internal Injuries, Inadequate Guardianship, Lack of Medical Care, Lack of Supervision,

and Parent's Drug / Alcohol Misuse were substantiated against the mother and father. The investigation determination noted the parents lack of a plausible explanation for the child's injuries, lack of supervision in leaving the child alone in the home for 90 minutes while they used marijuana in the car, and delay in obtaining proper medical care for the child after discovering him unresponsive as factors which contributed to the child's serious injury and hospitalization. The allegation of DOA / Fatality was unsubstantiated against both parents as the autopsy report and death certificate were not finalized at the time of the investigation determination and the medical examiner reported the cause of death remained pending at that time.

Immediately after the death of the child, the mother moved out of state and the father retained an attorney. Both parents ceased contact with MCDHS. As a result, MCDHS was unable to further their investigative efforts or offer services to the parents.

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 was no safety assessment due at the time of the determination as there were no surviving siblings.

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:
MCDHS conducted an investigation that met 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

Child Fatality Report

Incident Information

Date of Death: 07/12/2022 **Time of Death:** 12:13 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: Unknown
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

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 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

MCDHS initiated an investigation immediately upon receiving the SCR report on 7/8/2022 and continued their investigative efforts after receipt of the subsequent report following the the child's death on 7/12/2022. MCDHS interviewed the mother and father, notified the district attorney's office, and gathered information from law enforcement, the medical examiner, EMS, urgent care staff, and hospital staff.

MCDHS interviewed the parents separately at the hospital. The mother reported she had been outside of the house the entire day leading up to the child being found unresponsive and stated the father had come outside to join her between 12:00 and 1:00 PM when the child was placed down for a nap. The mother stated they did not have a baby monitor, and no one was inside watching the child at that time. The mother stated she and the father were using marijuana outside together. The father reported he had been watching the child on the morning of 7/8/2022 and went upstairs for a few minutes to get the child a diaper. The father stated he heard a bang while he was upstairs and returned to the kitchen to find the child had fallen out of a chair. The father stated he believed the child had climbed onto the chair to try to reach food that was on the kitchen counter. The father stated he did not notice any injuries on the child at that time, and then put the child down for a nap in a portable crib around 1:00 PM, at which time the child was crying, whining, and kicking. The father stated he then went outside to spend time with the mother, leaving the child unsupervised inside the home, and that he and the mother were using marijuana at that time. The father checked on the child around 2:00 PM and saw that the child was laying on

his right side and breathing. The father checked on the child again just before 4:00 PM and reported "there was something wrong." Both parents reported the father got the mother from outside, and they decided to bring the child to the urgent care center down the street. The father reported he may have shaken the child when trying to wake him up but could not be sure. Both parents denied substance use aside from marijuana.

MCDHS gathered and reviewed body-camera footage from law enforcement's initial response to the home, urgent care, and hospital on 7/8/2022. The footage captured conversations between the parents, law enforcement, and medical staff at the urgent care center and hospital. Upon questioning at the urgent care center and initial questioning at the hospital, both parents denied that the child fell or suffered any injury that day that could have led to his hospitalization; however, the father later reported to a doctor in the emergency room that the child had fallen out of a chair.

Information gathered by MCDHS from law enforcement, medical providers, and the parents, showed the parents reported conflicting information regarding the timing and events of 7/8/2022.

MCDHS spoke with the maternal grandmother who lived out of state. The grandmother reported she had previous concerns for the mother's ability to care for the child and described an incident when the mother was upset by the child's crying and began to yell and hit a pillow.

MCDHS spoke with the unrelated home member, who had been renting a room to the parents at the time of the death. The unrelated home member reported he was unaware of either parent being violent toward the child at any time. When asked if the child may have climbed onto or fallen out of a chair, the unrelated home member reported he did not believe the child had the ability to climb onto a chair. The unrelated home member reported he was in the process of evicting the parents.

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 referred this fatality to their Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060970 - Deceased Child, Male, 1 Year(s)	060994 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
060970 - Deceased Child, Male, 1 Year(s)	060995 - Father, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
060970 - Deceased Child, Male, 1 Year(s)	060994 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060994 - Mother, Female, 24 Year(s)	Internal Injuries	Substantiated

060970 - Deceased Child, Male, 1 Year(s)	060994 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060994 - Mother, Female, 24 Year(s)	Lack of Supervision	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060994 - Mother, Female, 24 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060995 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060995 - Father, Male, 28 Year(s)	Internal Injuries	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060995 - Father, Male, 28 Year(s)	Lack of Medical Care	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060995 - Father, Male, 28 Year(s)	Lack of Supervision	Substantiated
060970 - Deceased Child, Male, 1 Year(s)	060995 - Father, Male, 28 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The record does not reflect services were offered to the parents after the child's death; however, neither parent cooperated or remained in contact with MCDHS after the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Neither parent cooperated with MCDHS after the death of the child. The father retained an attorney and declined to speak further with MCDHS. The mother moved out of state and did not respond to attempts at contact.

History Prior to the Fatality

Child Fatality Report

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

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

MCDHS gathered records which showed the subject mother was listed as a subject on 5 CPS investigations between March 2021 and April 2022 in the state of Indiana. The investigations regarded concerns for substance misuse, unsanitary living conditions, and child abandonment against the subject mother regarding the deceased child. The record does not specify if the investigations were indicated or unfounded.

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.

Additional Local District Comments

Monroe County has reviewed this report and we are in agreement with the findings. We have no additional comments.

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