

Child Fatality Summary

Child's Name: [REDACTED]

County: Baker

Date of Birth: May 15, 2022

Date of Death: August 5, 2022

Report Number: 2022-233768

Family Composition Chart

| Name | Age at Time of Incident | Relationship with Deceased Child |
|------------|-------------------------|--|
| [REDACTED] | 11 weeks | Deceased Child |
| [REDACTED] | 21 months | Sibling |
| [REDACTED] | 17 | Mother of [REDACTED] Children |
| [REDACTED] | 19 | Father of [REDACTED] Children |
| [REDACTED] | 16 | Child in home (Maternal Aunt) |
| [REDACTED] | 15 | Child in home (Maternal Aunt) |
| [REDACTED] | 13 | Child in home (Maternal Uncle) |
| [REDACTED] | 11 | Child in home (Maternal Uncle) |
| [REDACTED] | 8 | Child in home (Maternal Aunt) |
| [REDACTED] | 5 | Child in home (Maternal Aunt) |
| [REDACTED] | 4 | Child in home (Maternal Uncle) |
| [REDACTED] | 2 | Child in home (Maternal Uncle) |
| [REDACTED] | 3 months | Child in home (Maternal Uncle) |
| [REDACTED] | 39 | Maternal Grandmother (Mother of [REDACTED] Children) |
| [REDACTED] | 66 | Maternal Grandfather (Father of [REDACTED] Children) |

1. Circumstances Surrounding Death

On August 5, 2022, this 11-week-old child was found unresponsive in the bassinet by the maternal grandmother. Law Enforcement (LE) and Emergency Medical Services (EMS) arrived and assessed the infant was already deceased. EMS pronounced the infant deceased 6:37am.

On the night of the incident, the father recalled propping up a bottle to begin feeding the infant while he was in the bassinet, but then finished the feeding while holding him. Around 11:00pm, the father placed the infant, along with blankets, back in the bassinet. The parents reported that the infant normally woke up throughout the night for additional feedings but did not wake on the evening/morning of the incident. The bassinet was in the living room and was observed to be dirty with blankets inside. The family reported that the infant was not exhibiting any signs of illness and did not have any pre-existing medical conditions.

The infant resided with the mother, maternal grandparents, and the mother's nine younger siblings. The father reportedly did not reside in the home; however, would visit often and assist with caregiving responsibilities. The condition of the residence was found to be cluttered due to the amount of people residing in the three-bedroom mobile home, with only two bedrooms being utilized for sleeping. The third unoccupied bedroom had a roof leak. The residence had water-

stained ceiling tiles, some missing ceiling tiles, roaches throughout the home, as well as a strong odor. The children’s clothes were dirty, and they appeared to have poor hygiene.

Each parent/caregiver submitted to a drug screen. All adults besides the father were negative for all tested substances. The father tested positive for methamphetamine, amphetamine, and marijuana, and stated that he used methamphetamine in the recent past to stay awake while caring for the infant.

The Baker County Sheriff’s Office opened an investigation which was closed on December 15, 2022, without pursuing criminal charges.

The Medical Examiner completed an autopsy and determined the cause of death as complications of pneumonia of probable viral etiology. The manner of death was natural.

The First Coast Child Protection Team (CPT) completed a medical records review on May 16, 2023. CPT had positive findings for fatal neglect stating, “Neglect-due to unsafe sleep as the child was found on his face where he was likely laid down in that position coupled with the blankets in the bassinet and being sick it is likely that he died of combination of unsafe sleep and viral disease. It is believed Viral pneumonia is a possible cause of death. However, this was clinically unappreciated.”

Based on the information obtained during the investigation, DCF Duval County Child Protective Investigations closed the investigation on September 1, 2023, with not substantiated indicators of death and substance misuse-illicit drugs, no indicators of substance misuse-alcohol, and verified findings of inadequate supervision.

Other Children in the Family

The child had one minor sibling at the time of the fatality who was deemed safe in the mother’s care. Immediately after the fatality the father had no contact with the family. Several months later, he re-established his involvement with the family and was referred to Gateway for a substance abuse and mental health assessment. The mother was referred to Daniel Kids for parenting and mental health counseling. Also, a referral for childcare was provided.

At the time of the fatality, the maternal grandparents and their young children were open to case management services due to a report received in April 2022. The report was received with concerns for the grandmother’s substance use as she was positive for buprenorphine and THC at the delivery of her youngest child and did not have a prescription. As a result, the younger children were determined to be unsafe, and a safety plan was implemented. The family transitioned to case management for in-home non-judicial services and was referred to FIS, counseling, and daycare. The mother and her child (the deceased infant was not yet born at the onset of this investigation) were deemed safe and not made part of the case management case or services.

2. Summary of Prior Agency Involvement with Family

In July 2022, a report was received concerning inadequate supervision that involved the mother and father as the alleged perpetrators, and their two children. The family was living with the maternal grandmother, grandfather and the mothers’ siblings at the time. This case was closed with no indicators as the allegations were denied by all members of the household and the case manager overseeing the grandmother’s case.



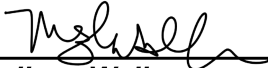
Given the circumstances surrounding the family's recent involvement with the child welfare system, a Special Review Team conducted a review of the most recent prior history to assess the prior interventions with the family and any potential issues within the local system of care. The review team's report can also be found on the department's Child Fatality Prevention website, at <https://www.myflfamilies.com/childfatality>.



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2/26/24

Date



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2/27/24

Date