Child Fatality Report

Report Identification Number: BU-22-025

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

Issue Date: Apr 19, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Orleans
Gender: Male
Date of Death: 10/23/2022
Initial Date OCFS Notified: 10/23/2022

Presenting Information

The SCR report alleged that on 10/23/22, at approximately 7:15AM, the father gave the subject child a bottle and went to bed with the subject child. Although the subject child had a bassinet next to the parent's bed, the father placed the child in the middle of the parent's bed on his right side, facing him. At approximately 9:12AM, the father woke up and found the subject child unresponsive and not breathing. The father called the mother and then 911. It was unknown if the father performed cardiopulmonary resuscitation. At 9:26AM, the police arrived and found the subject child unresponsive on the floor in the living room. At 9:31AM, emergency medical technicians unsuccessfully attempted cardiopulmonary resuscitation, and the subject child was pronounced deceased in the home. There was concern that the unsafe sleeping environment contributed to the subject child's death.

Executive Summary

This fatality report concerns the death of the 3-month-old male subject child that occurred on 10/23/22. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the father. The allegation of Inadequate Guardianship was added against the mother. At the time of his death, the subject child resided with his mother, father, and maternal grandparents. There were no surviving siblings or other children in the household.

Orleans County Department of Social Services (OCDSS) completed collateral and casework contacts and learned that on 10/23/22, the mother got up with the subject child around 4:35AM. The mother fed the subject child a bottle, changed him, and got ready for work. The mother left for work just before 6:00AM and left the subject child with the father. The father fed and changed the subject child again and laid down with the subject child in the parents' double-sized bed. The father placed the subject child on the mother's side of the bed and went to sleep. The father awoke between 9:00-9:30AM and observed the subject child unresponsive. The father called the mother at work and then called 911. The father attempted cardiopulmonary resuscitation until emergency medical services arrived.

An autopsy was performed, and the final cause and manner of death were pending at the time the CPS investigation closed. The medical examiner who performed the autopsy noted no trauma to the subject child. The coroner, to whom the death was referred, reported concern regarding the parent's timeline of events. The coroner stated the subject child was in full rigor mortis, and it was suspected the subject child had been deceased for 6 to 8 hours. First responders, however, stated the subject child was still warm while cardiopulmonary resuscitation was being administered. Law enforcement did not suspect there was criminality related to the subject child's death, and no charges were pending.

Bereavement services were offered to the family and declined. The mother was previously engaged with a mental health counselor and planned to continue seeking services through her existing provider. The allegations of Inadequate Guardianship against the mother and father were substantiated, and the allegation of DOA/Fatality against the father was substantiated. The case was indicated and closed on 12/8/22.

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?** 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:
OCDSS made an appropriate decision to substantiate the allegations against the SM and SF based on evidence obtained throughout the investigation.

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:
Casework activity was commensurate with casework 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: 10/23/2022 **Time of Death:** Unknown

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

County where fatality incident occurred: Orleans
Was 911 or local emergency number called? Yes
Time of Call: 09:22 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	20 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	43 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDSS coordinated their investigation with law enforcement, notified the DA's office, spoke with collateral sources, conducted a home visit, and interviewed all household members.

OCDSS interviewed the SM and SF and learned that on 10/23/22, the SM woke up around 4:35AM to feed and change the SC. The SM got ready and left for work with the MGM just before 6:00AM. The SF fed and changed the SC and laid down with the SC between 6:30-7:00AM. The SF placed the SC in the parent's bed, on the SM's side and went to sleep. The MGF left for work around 8:30AM. The SF reported waking up between 9:00-9:30AM, and the SC was snuggled into the SF's side with his face straight up and unobstructed. The SF noticed the SC was unresponsive and called the SM. The SF then called 911 and was instructed to place the SC on a hard floor to perform CPR. The SF brought the SC downstairs and began CPR until EMS arrived. The SC was later pronounced deceased at the home. The SM reported receiving a phone call from the SF that the SC was not breathing, found the MGM, and left work to return home. The SM and SF were questioned regarding the concern about the timeline of events and the SC possibly being deceased longer than initially stated; however, the parents provided the same version and timeline of events.

The MGM and MGF were interviewed. The MGF initially reported hearing the SC fussing and crying around 7:53AM when he let the family dogs outside; however, when the parent's timeline was questioned, the MGF was "second-guessing" if he heard the SC that morning. The MGM reported that the SM did not want to go to work that day because she was worried about the SC. When the MGM asked the SM why she was concerned about the SC, the SM did not provide a reason. The MGM stated the SM did not bring the SC downstairs as she usually does. The MGM reported that the SM and SF did not follow safe sleep guidelines, and the MGM would continuously address safe sleep with the parents. The MGM reported having to wake the parents on occasions because there was a blanket over the SC's face.

During a home visit, OCDSS observed the parents had a portable crib for the SC. The parents were aware of safe sleep guidelines but regularly co-slept as they did not think anything would happen.

The SC was last seen by his pediatrician on 9/7/22, and no concerns were noted. The SM and SF were providing the SC with gas drops which had been recommended by the pediatrician. The parents reported they were giving the SC melatonin. The SC's pediatrician stated they would not recommend melatonin for a child that age, and the effect on a child that age was unknown. After obtaining a bottle of medicine from the home, OCDSS determined the parents were providing nighttime gas drops, and it was not believed the parents gave the SC melatonin.

Official Manner and Cause of Death

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

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: Orleans 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
063088 - Deceased Child, Male, 3 Mons	063089 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated
063088 - Deceased Child, Male, 3 Mons	063090 - Father, Male, 20 Year(s)	Inadequate Guardianship	Substantiated
063088 - Deceased Child, Male, 3 Mons	063090 - Father, Male, 20 Year(s)	DOA / Fatality	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The SM was engaged in MH counseling prior to the SC's death and planned to continue receiving services through her existing provider. The MGF was observed consuming alcohol during multiple home visits, but further service needs were not explored or offered.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
Bereavement services were offered to the family but refused. The SM stated that she was engaged in mental health counseling prior to the subject child's death and would continue to receive services through her current provider.

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

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 is no known history outside of New York State.

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