Child Fatality Report

Report Identification Number: RO-23-013

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

Issue Date: Nov 15, 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 year(s)
Jurisdiction: Chemung
Gender: Male
Date of Death: 07/07/2023
Initial Date OCFS Notified: 07/07/2023

Presenting Information

Multiple reports were received between 7/2/23 and 7/3/23 regarding the fatal incident, which occurred on 7/2/23. The fatality report was received on 7/7/23, and alleged that on 7/2/23, the subject child was in the care of the mother and father. The child was playing outside and ingested a quantity of unknown opioids. The mother witnessed the child chewing on something after he played in the backyard but did not look to see what it was. Approximately 20 minutes later, while watching television with the father, the child began to vomit red bile and became unresponsive. The father ran out of the home to get help. A neighbor came and performed cardiopulmonary resuscitation on the child while the father called 911. The child was taken to the hospital by ambulance, arriving at 12:57PM. The child was then airlifted to a different hospital for pediatric intensive care services. The child had been hospitalized continuously, until 7/7/23, when he was pronounced dead at 2:06PM.

Executive Summary

This report concerns the death of the 2-year-old subject child. Chemung County Department of Social Services (CCDSS) received an SCR report regarding the child's death on 7/7/23. This report was received following four previous SCR reports received regarding the incident precipitating the death, which occurred on 7/2/23. At the time of the child's death, he resided with his mother, father, and two siblings, ages 2 and 4.

It should be noted the parents had varying accounts of the events leading up to the fatal incident and it was learned the mother was deceptive during a polygraph test and admitted to fabricating her recollection of events. On the evening of 7/1/23, after putting the children to bed, the parents had friends over for a party. People began arriving sometime between 8-10:00PM. The father said that just about everybody he knows "dabbles" in drugs, and there was beer and cocaine being consumed at the home that evening. The father said cocaine was used in the living room and kitchen; however, the mother reported the gathering occurred on the front porch and people only went inside to use the bathroom. Their friends left sometime between 12-3:00AM and the parents went to bed. The following morning, around 8:00AM, the mother got up with the child and 2-year-old sibling, fed them pancakes, and they went outside to play in the front yard. The mother initially reported that while outside, she saw the child put something in his mouth that looked like a purple piece of chalk. She later admitted the child put the purple substance in his mouth while inside the home. Shortly after ingestion, the child began acting differently; he was nodding his head and wheezing, as if gasping for air. He sat on the father's lap and the father asked if he was okay, to which the child reportedly responded, "I okay, daddy" and then closed his eyes. The mother noticed a pinkish-orange vomit-like substance against the father's white shirt and when the father looked at the child, his lips were blue. The father put the child down and ran to the neighbors to call 911. The father was on the phone with 911 while CPR was being attempted. Multiple agencies responded to the home and the child was transported via ambulance to the hospital. The child arrived at the hospital in cardiac arrest and medical staff was able to obtain a return of spontaneous circulation. The child was airlifted to a second facility, where he was placed on life-support and ultimately died upon the cessation of that support on 7/7/23.

Medical collaterals confirmed that upon arrival, a toxicology screen was positive for fentanyl despite no opioids administered by any medical providers. The hospital attributed the death to a hypoxic brain injury. The case was referred to and accepted by the medical examiner, although the final autopsy had not yet been received. Law enforcement investigated and confirmed the substances found in the home included cocaine found on the couch and in the garbage can, as well as fentanyl, found near where the child was. Possible charges were pending the final autopsy and the case was referred to drug enforcement.

A safety plan was immediately developed to protect the siblings. The siblings stayed with appropriate relatives, who were willing and able to supervise the parents' contact. The maternal grandmother petitioned for and was awarded custody under Article 6 and the siblings were assessed safe in her care. Further family court action was considered; however, the surviving siblings no longer resided in the state upon the granting of custody under Article 6.

CCDSS made the appropriate determination to substantiate the allegations against the parents regarding the death of the child, as well as all other allegations contained in the report concerning the child and siblings.

PIP Requirement
For citations identified in historical cases CCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS will review the plan and revise as needed to address ongoing concerns.

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

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:
CCDSS conducted an investigation that met all regulatory guidelines. As there were no children in the custody of the parents, the case was appropriately closed upon the completion of the CPS investigation. The parents were provided with CCDSS's recommendations and information on relevant community-based providers.

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: 07/07/2023 **Time of Death:** 02:06 PM

Date of fatal incident, if different than date of death: 07/02/2023
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Chemung
Was 911 or local emergency number called? Yes
Time of Call: 12:27 PM
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	Male	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

Between 7/2/23 and 7/3/23, CCDSS received four SCR reports which said the subject child was hospitalized after having ingested drugs. The child went into cardiac arrest and was placed on life-support. A fatality report was registered on 7/7/23 following the child's removal from life-support. CCDSS initiated their investigation into the fatal incident on 7/2/23. The siblings' safety was assessed and resulted in the need for a safety plan. CCDSS worked with the family and relatives to develop an appropriate plan in which the siblings were cared for by approved relatives and the parents were permitted supervised contact only. The plan remained in place until Article 6 custody was granted on 7/10/23 to the maternal

grandmother and the siblings were assessed to be safe in her care with the support of a court order restricting the parents' contact. During the investigation, the siblings relocated out of state with their now custodial grandmother.

CCDSS, along with Monroe County Department of Human Services (MCDHS), interviewed the parents regarding the events leading up to the fatal incident. MCDHS assisted with interviews due to the location of the hospital and some relatives. Various descriptions of the incident were provided. The mother and father both reported they had a small party at the house the evening of 7/1/23. The children were asleep at the time. The father said he and the other adults were drinking beer and using cocaine. The mother initially denied any knowledge of drug use at the party; however, during a polygraph examination, admitted she, the father, and other adults were using cocaine that night. Additionally, she saw two adults snorting a purple-colored substance from a bag. The other adults left the home sometime after midnight and the parents went to bed. An adult who was at the house the night before returned to the home at 8:00AM the next morning, looking for what the mother said was marijuana that had been left. The mother recalled at one point last evening, she observed one of the adults who had snorted the purple-colored substance searching for something near the front door but failed to identify what they were searching for. Around 8:00AM, the mother brought the child and 2yo sibling outside. The mother initially stated while outside, she saw the child put what looked like a piece of purple chalk in his mouth, which she removed and tossed into the yard. They then came inside to begin getting ready for the child's birthday party. Between 11:30AM and noon, the father was on the couch when the mother came back inside and told him the child had picked something up and put it in his mouth. The child went over to the father and sat on his lap. He began to wheeze and put his head on the father's chest. A few minutes later, the mother asked the father what was on his shirt, referring to a pinkish-orange vomit-like substance seen where the child was laying. The father set the child on the couch and realized he was not breathing, and his lips were blue. The father ran out of the house to a neighbor to call 911. The father was on the phone with dispatch while the neighbor and mother attempted CPR.

Collateral contact with medical staff revealed the child received 30 minutes of CPR before a return of spontaneous circulation was obtained. The child was airlifted to a pediatric intensive care unit for a higher level of care on 7/2/23. The child had a severe hypoxic brain injury and was found to be positive for fentanyl. The child was given two consecutive brain death exams, both consistent with the cessation of neurologic function. The child was removed from life-support and his death was declared on 7/7/23.

Both parents were referred for substance use evaluations and mental health treatment, and parenting education was recommended. The parents had no other children in their care, the siblings were assessed to be safe with the grandmother, the report was indicted and closed.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

064479 - Deceased Child, Male, 2 Yrs	064482 - Mother, Female, 34 Year(s)	Poisoning / Noxious Substances	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064483 - Father, Male, 43 Year(s)	Poisoning / Noxious Substances	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064483 - Father, Male, 43 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064482 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064482 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064482 - Mother, Female, 34 Year(s)	Lack of Supervision	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064482 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064483 - Father, Male, 43 Year(s)	Lack of Supervision	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064483 - Father, Male, 43 Year(s)	DOA / Fatality	Substantiated
064479 - Deceased Child, Male, 2 Yrs	064483 - Father, Male, 43 Year(s)	Inadequate Guardianship	Substantiated
064480 - Sibling, Male, 4 Year(s)	064483 - Father, Male, 43 Year(s)	Inadequate Guardianship	Substantiated
064480 - Sibling, Male, 4 Year(s)	064482 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
064480 - Sibling, Male, 4 Year(s)	064482 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064480 - Sibling, Male, 4 Year(s)	064483 - Father, Male, 43 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064481 - Sibling, Male, 2 Year(s)	064482 - Mother, Female, 34 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
064481 - Sibling, Male, 2 Year(s)	064482 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
064481 - Sibling, Male, 2 Year(s)	064483 - Father, Male, 43 Year(s)	Inadequate Guardianship	Substantiated
064481 - Sibling, Male, 2 Year(s)	064483 - Father, Male, 43 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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:				

Although family court action was taken during the CPS investigation to protect the siblings, it was initiated by the filing of an Article 6 custody petition by the maternal grandmother. Child protective proceedings under Article 10 were considered; however, the children had already been placed pursuant to Article 6 with the grandmother and no longer resided in NYS.

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?	☐	☒	☐	☐

Explain as necessary:
A formal removal was not conducted. A safety plan was utilized until custody was formalized under Article 6. Through coordination between CCDSS and relatives, the siblings were able to remain with family and were not placed into foster care.

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: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/07/2023	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	None	
Comments:	As a result of the fatality, the maternal grandmother petitioned family court for custody of the surviving siblings. The first appearance on the petition occurred on 7/10/23 and temporary legal and physical custody of the siblings was granted to the grandmother. The parents were granted electronic or in-person parenting time, supervised (eyes on, ears on), with the siblings as the parties can agree. It was further ordered that the parents were granted right of access to medical and educational providers for the siblings, there shall be no alcohol or drug use by the parents 24 hours prior to or during supervised parenting time and the grandmother will keep the court apprised of her contact information and ensure the siblings are enrolled in school. A subsequent hearing was held on 8/23/23, which the parents did not attend, and a final custody order was granted to the grandmother. CCDSS remained an interested party to any further proceedings regarding the petition. CCDSS maintained contact with the grandmother through the completion of the investigation. The grandmother reported the siblings were doing well and she had enrolled the 4yo SS in a pre-k program. The grandmother was provided relevant medical information on the siblings and medical appointments were scheduled.	

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 4yo sibling disclosed the presence of DV in the household. Both parents, interviewed separately, denied physical DV. The mother was offered referrals to DV services, which she declined. LE records requested did not show LE involvement due to DV.

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:
The siblings relocated out of state with their maternal grandmother shortly after the fatality. The grandmother had scheduled doctors appointments to establish the siblings with a primary care physician and expressed she would request a mental health referral at that time.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were provided with information on bereavement services. Due to service needs identified during the investigation, the parents were referred for substance use evaluations and mental health services. CCDSS also recommended the parents engage in parenting education services and provided information on service providers. The

father attended a substance use intake; however, missed subsequent appointments. He was on the waitlist for mental health. The mother had not engaged in services.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/07/2021	Deceased Child, Male, 1 Months	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report received on 8/7/21 alleged that the mother was co-sleeping with the subject child when she rolled over on top of him. At 6:00AM, the mother found the child not breathing and his nose was bleeding. The child was successfully resuscitated; however, remained in critical condition with the imminent possibility of death. The father was not known to have been sleeping with the child and mother.

Report Determination: Unfounded **Date of Determination:** 11/08/2021

Basis for Determination:
CCDSS unsubstantiated the allegation of Inadequate Guardianship against the mother regarding the child. CCDSS noted the mother's recollection changed multiple times regarding whether she co-slept, or whether the child slept in the travel bassinet. CCDSS concluded there was a lack of evidence to support that the mother did anything to purposefully harm the child, and the report was unfounded and closed.

OCFS Review Results:
The record was inconsistent. Progress notes and the 7-Day Safety Assessment reflected the unsafe sleep practice resulted in the child's injuries; however, the conclusion relied on the mother's intent as a basis for unsubstantiating the IG allegation. The hospital was not directly asked the cause of the child's diagnoses of acute hypercarbic and hypoxemic respiratory failure, shock, and acidosis. Safe sleep guidelines were reviewed with the mother on multiple occasions, and at the time the investigation was closed there were adequate sleeping provisions. The child was discharged from the hospital with home care, which was successfully completed, and medical appointments were being followed.

Are there Required Actions related to the compliance issue(s)? ☒ Yes ☐ No

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
Medical collaterals were not asked the cause of the child's diagnoses, and whether or not the child being found with a blanket over his head could have resulted in his medical state at that time.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:

CCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

[redacted]

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