Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-23-020

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

Issue Date: Mar 29, 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
Age: 1 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 11/02/2023
Initial Date OCFS Notified: 11/02/2023

Presenting Information

An SCR report alleged that on 11/02/23, at an unknown time, the 1-year-old child passed away while in the care of the parents. The father called 911 at 5:36 PM. First responders arrived and the child was found on the floor, inside of a bathroom closet. The child's skin was cold, and his body was stiff. He appeared to have died over 5 hours prior. As a result, no lifesaving measures were attempted. The child was pronounced dead at 5:44 PM. He was otherwise healthy, and the parents had no explanation for the death. A duplicate report was received on the same day.

Executive Summary

This report concerns the death of the 1-year-old SC that occurred on 11/02/23. Two reports were made to the SCR on the same day alleging that the SC died while in the care of his parents and the parents had no explanation for the death. At the time of his death, the SC resided with the SM. There were no surviving siblings or other children in the home.

Monroe County Department of Human Services (MCDHS) coordinated with LE upon receipt of the SCR reports. LE planned to arrest the SM for "murder 2nd, depraved indifference". An autopsy was performed; however, the final autopsy was not yet available at the time of this writing. Staff at the ME's office reported the SC was significantly malnourished, had hair loss and noted that the SC's legs would not be able to support his body weight. The SC had head trauma and marks about his body. It was presumed the SC died as a result of starvation and dehydration.

The SM reported that the SC was ill with infections for 4 days prior to his death. The SM did not respond to further questioning and was hospitalized for mental health concerns for the remainder of the investigation.

The SF reported he had not seen the SC for 4 to 6 months and that the SC appeared thin and ill in pictures. The SF said the SM notified him that the SC "was gone" and he went to the SM and SC's home. The SF reported the SM said the SC had been dead for 5 hours. The SF called 911 approximately 2 hours later.

First responders arrived and found the home to be unkempt and in disarray. The SC was found lying supine and lifeless on the bathroom floor. The SC was wearing a diaper that was on backward, a misbuttoned shirt, and had pants over his head. He appeared malnourished and his bones were prominent and protracting. No resuscitation efforts were made.

MCDHS contacted collaterals including firefighters, neighbors, and a paternal aunt. MCDHS reviewed the 911 call, shared records with LE and had communication with the ME's staff.

The allegations of IG and DOA/Fatality were unsubstantiated against the SF. The Investigation Conclusion Narrative reflected that although the SF received pictures of the SC, he did not appear to recognize the seriousness of the SC's weight loss. The SF did not appear to understand the seriousness of the condition of the SM's mental health. The Investigation Conclusion Narrative reflected that it was the SF's understanding that the SC died due to illness. The SF shared pictures of the SC with the aunt approximately 1-2 weeks prior to the death. The aunt stated she spoke to the SF about the SC's weight loss and noted that the SF did not seem to understand its seriousness, and that the SC looked fine to him. The SF should have been indicated for IG for failing to take any action to ensure the safety of the SC; therefore, the allegation was inappropriately determined. MCDHS added and substantiated the allegations of IF/C/S, M/FTTH, L/B/W, P/Nx, SDS and LMC against the SM. The SC had bruising and swelling near his eye, and he had lacerations/scars on his spine and side. The SC was immobile and therefore, he could not have caused the injuries to himself. The SM did not

provide the SC with ample food or water. A basis for determination was not documented for LMC or P/Nx.

MCDHS completed required reports timely, and they accurately reflected case circumstances. Progress notes were not entered contemporaneously to their event dates. The record did not reflect the parents were offered services in response to the death. The SM received psychiatric services. MCDHS documented thorough interviews with collateral contacts, conducted a home visit and attempted to gather information from the parents. After all casework activity was completed, the investigation was closed timely on 12/30/23.

PIP Requirement
MCDHS will submit a PIP to the Rochester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS 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:**
  - **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?** No

Explain:
Safety Assessments were not required as there were no surviving children. Some allegations were inappropriately determined.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
Casework activity was not commensurate with case circumstances as allegations were inappropriately determined. Some progress notes were not entered timely and Notice of Existence letters were not provided. The record did not reflect appropriate services were offered to the parents in response to the death.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The SF was advised by his relatives that the SC appeared to be losing weight, yet the SF failed to understand the possible seriousness of this, and the SF did not intervene to protect the SC; therefore, IG was inappropriately unsubstantiated.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	MCDHS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Rochester Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/02/2023 **Time of Death:** Unknown

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: 05:36 PM
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	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	23 Year(s)

LDSS Response

On 11/02/23, MCDHS received the fatality reports from the SCR. Within the first 24 hours of the investigation, MCDHS contacted the sources of the report, notified the ME and DA's offices of the death and coordinated investigative efforts

with LE.

MCDHS gathered information from LE who reported the SF called 911 to request an ambulance because the SC died. Upon arrival to the home, the SC was beyond resuscitation and the death appeared suspicious. According to LE, both parents appeared to have “significant underlying mental health issues”. LE contacted neighbors who reported they had not seen the SC in approximately a week and had concerns for the SM’s mental health. Neighbors reported the SM had odd behaviors and that the SC looked unhealthy and used to be bigger.

MCDHS and LE listened to the 911 call made by the SF. The SF said the SC had been dead for over 5 hours and that he had an infection and was “on pills”. Further information regarding "pills" remained unknown.

A home visit was conducted by the MDT on 11/02/23. The SC was found supine and lifeless on the floor. The ME said the SC was significantly malnourished and that his legs would not be able to support his body weight. There was head trauma and marks about his body.

MCDHS gathered information from a firefighter who noted the parents said they called 911 as the SC’s body could be cremated. He said the parents acted as if the death was expected. The SM reported that the child had a viral infection.

The SF said he had not seen the SC in person in approximately 4 to 6 months. The SF said the SM sent him a picture of the SC and the SC looked “a little skinnier and a little sicker” than the last time he had seen him. The SM told the SF the SC had died and he went to the SM’s home to learn the SC died 5 hours prior. The SF expressed the SM said the SC fell ill on 11/02/23. The SF had not seen the SC walk and noted the SC’s legs looked too weak to do so. The SF was aware the SC’s hair was falling out. He reported the SM admitted to “karate chopping” the SC’s throat to stop him from crying.

The SM was interviewed and said the SC was ill for 4 days prior to his death and that he had infections. The SM stopped responding to questions and was “staring off”. The SM was admitted to a psychiatric hospital where she remained throughout the investigation.

The aunt was contacted and reported the SF historically sent her pictures of the SC and he “had a lot of weight on him”, but about 1-2 weeks prior to the death, the SF sent pictures to another aunt. It was reported the SC looked like he was not being fed. The aunt discussed the weight loss with the SF, but the SF did not seem to understand and would say that the SC looked fine to him.

MCDHS maintained communication with the MDT throughout their investigation. Information from LE reflected there was no food in the SC’s stomach during the autopsy, but there were beads, cigarette butts and a bottle cap in his colon. The SF reported to LE that the SM said the SC was deceased for a week. LE records reflected the neighbors reported the SC was small, and the SM had odd behaviors such as throwing food, writing on walls and carrying the SC “like a sack of potatoes.” The SM had researched the terms CAC and head trauma approximately a month prior to the death. Further information gathered from the ME reflected the SC weighed 12 pounds, had sunken eyes, significant muscle loss and was dehydrated. The official cause and manner of death remained pending at the time of this writing.

Official Manner and Cause of Death

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

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: The death was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	Lacerations / Bruises / Welts	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	Lack of Medical Care	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	Malnutrition / Failure to Thrive	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	Poisoning / Noxious Substances	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066474 - Mother, Female, 34 Year(s)	Swelling / Dislocations / Sprains	Substantiated
066473 - Deceased Child, Male, 1 Year(s)	066475 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
066473 - Deceased Child, Male, 1 Year(s)	066475 - Father, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated

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 record did not reflect MCDHS offered services to the parents in response to the fatality. The mother was in a

psychiatric hospital at the time of this writing.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The record did not reflect the parents were offered services in response to the fatality.

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? Yes

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 CPS history outside of New York.

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 does not agree with the citation as we do not feel that there is a fair preponderance of evidence to support an allegation of Inadequate Guardianship against the father.

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