



Report Identification Number: SV-23-032

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

Issue Date: Dec 06, 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: 8 month(s)

Jurisdiction: Orange
Gender: Male

Date of Death: 06/26/2023
Initial Date OCFS Notified: 06/26/2023

Presenting Information

An SCR report was received on 6/26/23 and alleged the 8-month-old subject child had a history of sustaining redness on his legs. On 6/26/23, around 1:00PM, the subject child sustained redness on his legs and was crying inconsolably. As a result, the mother and the father drove the subject child to the hospital and arrived at 2:16PM. During the car ride, the subject child vomited once. While at the hospital, the subject child fell asleep in the father's arms for an unknown length of time. At 4:45PM, the mother noticed the child was pale and unresponsive, and notified medical staff. As a result, medical staff began performing cardiopulmonary resuscitation with no success. The subject child was pronounced deceased at 6:31PM. The subject child was an otherwise healthy child, the mother and the father did not have an explanation for his death.

Executive Summary

This report concerns the death of an 8-month-old male child that occurred on 6/26/23. Orange County Department of Social Services (OCDSS) received an SCR report on 6/26/23, regarding the fatality. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and father of the subject child. At the time of his death, the subject child resided with his mother, father and 8-year-old sibling. OCDSS immediately initiated their investigation and assessed the 8-year-old surviving sibling to be safe in his parents' care.

Through a joint investigation with law enforcement, it was learned on 6/26/23, the subject child was being cared for by his mother. The subject child was observed with redness to his legs and was inconsolable. The mother fed the child, and he immediately threw up. The mother contacted the father who agreed to take the child to urgent care. When the father arrived home, the mother and father decided to take the child to the emergency room. The family arrived at the hospital and while there, the mother observed the child to be unresponsive. Medical staff attempted life-saving efforts; however, were unsuccessful and the child was pronounced deceased at 6:31PM.

OCDSS communicated with law enforcement and learned there were no concerns for abuse or maltreatment and there were no pending criminal charges against the parents. OCDSS communicated with the medical examiner's office as well as hospital staff and learned there were no signs of trauma to the child or suspicious injuries. The medical examiner stated there were no concerns for foul play. A preliminary autopsy was completed, and it was the opinion of the medical examiner that the death was a medical anomaly. OCDSS received the final autopsy results and learned the cause of death was complications of congenital diaphragmatic hernia and the manner of death was natural. Regarding the subject child's medical issue, the medical examiner stated it would have been unlikely any doctor would have discovered the issue.

OCDSS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother and father and closed their investigation on 8/3/23. Safety and risk assessments were completed timely and accurately. Progress notes were entered contemporaneously, and all required notifications were provided. OCDSS gathered pertinent information from collateral contacts such as the children's pediatrician, medical staff, law enforcement and the sibling's school district.

OCDSS discussed the process for burial assistance and referred the family for grief counseling which the family accepted and was actively participating in at the time this report was written. In addition, the 8-year-old sibling was receiving counseling services at school.

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

Explain:
 OCDSS made an appropriate decision to unsubstantiate the allegations of DOA/Fatality and Inadequate Guardianship based on evidence obtained throughout their 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 case 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: 06/26/2023

Time of Death: 06:31 PM

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

02:10 PM

County where fatality incident occurred:

Orange



Was 911 or local emergency number called? No
 Did EMS respond to the scene? No
 At time of incident leading to death, had child used and/or ingested alcohol or drugs? No

Child's activity at time of incident:

- Sleeping Working Driving / Vehicle occupant
 Playing Eating Unknown
 Other: At the hospital awaiting treatment.

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	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)

LDSS Response

On 6/26/23, OCDSS received a report regarding the death of the subject child. OCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. OCDSS contacted the source of the report, communicated with the district attorney and the medical examiner. OCDSS immediately assessed the surviving sibling to be safe in the home and in the care of the parents.

On 6/27/2023, OCDSS interviewed the mother at the family's home, regarding the fatality. The mother explained on 6/26/23 the children woke up around 7:00AM. The mother immediately fed the subject child with no issues and the subject child crawled around on the floor. Between 9 and 10:00AM the mother put the subject child down for a nap in his crib. The subject child woke from his nap between 11 and 12:00PM and was fussy, so the mother put him on the floor to play. Around 1:00PM, the subject child began crying, the mother gave the child a bottle and he immediately threw up. The mother observed his vomit was yellow in color and was more consistent with bile than formula. The mother noted the subject child's legs were red and she had seen this once before in November. The mother reported she had contacted the pediatrician in November regarding the redness, and the pediatrician had no concern and provided no recommendations. The mother then contacted the father who agreed to leave work to bring the subject child to urgent care. The father arrived at the residence between 1:45PM-2:00PM and the parents decided to bring the child to the emergency room and arrived at 2:10PM. The mother reported medical staff took the subject child in the back and she believed he was being treated; however, later learned the child awaited testing that had not been completed. The mother reported that after three hours the child was not hooked up to any monitoring systems. The mother explained she and the father were taking turns staying in the room with the subject child. The mother noticed the child was pale and unresponsive and at that time, medical staff began attending to him and he passed shortly after.

On 6/27/2023, OCDSS interviewed the father at the family's home, regarding the fatality. The father explained he went to work at 6:00AM and around 1:00PM, the mother called him stating she felt the subject child needed to see a doctor. The



father arrived home around 2:00PM and they immediately left for the emergency room. The father explained he is unsure what the medical staff were doing at the hospital and noted he felt his son would be alive if they had brought him to the hospital where he was born.

On 6/27/2023, OCDSS interviewed the 8-year-old sibling at the family’s home, regarding the fatality. When the sibling was asked what happened to the subject child, he explained his brother threw up and “became a ghost and he’s dead.” The sibling reported feeling safe with his parents and denied any concerns for domestic violence, substance abuse or physical discipline.

OCDSS communicated with the children's pediatrician and learned the parents were attentive with the children's medical care. The pediatrician was unable to provide an explanation as to how or why the child may have died as he was developing well and was up to date with him immunizations. The subject child was last seen on 4/12/23 for his 6-month well visit and had a scheduled 9-month appointment on 7/5/23. There were no medical concerns noted for the subject child. The 8-year-old surviving sibling had his last well visit on 6/1/23 and there were no concerns for his physical health.

Official Manner and Cause of Death

Official Manner: Natural

Primary Cause of Death: From a medical cause

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: This case was referred to Orange County's Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064277 - Deceased Child, Male, 8 Mons	064278 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
064277 - Deceased Child, Male, 8 Mons	064278 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
064277 - Deceased Child, Male, 8 Mons	064279 - Father, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
064277 - Deceased Child, Male, 8 Mons	064279 - Father, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain as necessary:

The 8-year-old surviving sibling was immediately assessed to be safe in the care of his parents.

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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:

OCDSS referred the 8-year-old sibling for grief counseling services.

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

Explain:

OCDSS discussed burial assistance with the mother and father and also referred the family for grief counseling services which the family accepted.

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? 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 CPS 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