Child Fatality Report

Report Identification Number: SY-23-007

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

Issue Date: Jul 21, 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: 3 month(s)
Jurisdiction: Broome
Gender: Male
Date of Death: 02/11/2023
Initial Date OCFS Notified: 02/11/2023

Presenting Information

Broome County Department of Social Services (BCDSS) received two reports on 2/11/23 regarding the subject child's death. The reports alleged sometime around 10:45AM, the mother placed the child in his bassinet to sleep. The father checked on the child at about 12:30PM and found him unresponsive and not breathing. The mother called 911. EMS arrived at the home and the father was holding the child. EMS did not perform resuscitative measures because it was evident that the child was deceased, and rigor mortis had set in. The child was pronounced deceased at the home at approximately 12:58PM. The child was an otherwise healthy child, and the parents had no explanation for the child's death. The 5-year-old sibling had an unknown role. BCDSS received a subsequent report on 2/14/23, regarding the child's death and the condition of the home being unsanitary and cluttered, which posed a safety risk to the child and the sibling. A subsequent report was received on 6/22/23, it alleged the child was not being fed during the day, then at night the parents overfed the child to the point he vomited. The parents used methamphetamines to the point of impairment while caring for the child and the sibling, and they were verbally aggressive. The condition of the home was a safety hazard with animal feces throughout.

Executive Summary

On 2/11/23, BCDSS received two SCR reports regarding the death of the 3-month-old male subject child. At the time of the child's death, he resided with his mother, father, and 5-year-old female sibling. The sibling was visiting with her father when the fatal incident occurred and was not in the home. The record did not reflect BCDSS interviewed the father of the 5-year-old sibling.

On 2/11/23 at about 8:00AM, the mother fed the child a bottle, then placed him in the bassinet on his side wrapped in a blanket with a pillow under his head. Sometime between 9:00AM and 10:00AM, the mother checked on the child, he was awake, and the mother placed a pacifier in his mouth. The mother fell asleep on the couch. Between 12:00PM and 12:30PM, the father woke up and went to check on the child. The father found the child in the bassinet, unresponsive, not breathing, and the child was cold and stiff. The father picked up the child and yelled for the mother. The mother called 911. First responders arrived at the home and EMS did not perform resuscitative measures because it was evident the child was already deceased. The child was pronounced deceased at the home at approximately 12:58PM.

An autopsy was performed; however, the final report had not yet been received at the time this report was written. There was no trauma or injury to the child's body. The coroner had tissue testing done due to concerns regarding the family's water, and the results were pending. Law enforcement investigated the death and found no criminality and their investigation remained open pending the final autopsy report.

The CPS investigation remained open at the time this report was written; therefore, a determination had not been made and the allegations of Inadequate Guardianship and DOA/Fatality against the mother and father regarding the subject child were pending. The record did not reflect BCDSS contacted or interviewed the father of the 5-year-old sibling. The record showed there was no contact with the family from 2/15/23 to 6/23/23, although there were concerns for the mother and father's mental health, and ongoing medical concerns for the sibling. The mother reported her mental health was escalating and she was inconsistent taking her medication. The parents refused mental health services offered by BCDSS. There was no casework activity from 3/3/23 to 4/4/23 and 4/6/23 to 6/6/23. On 6/6/23, BCDSS attempted a phone call to the mother and the phone was not in service.

PIP Requirement

BCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the BCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, BCDSS 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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:

Casework activity was not commensurate with the casework circumstances. The father of the SS was not contacted, or interviewed regarding the report. There was no contact with the family from 2/15/23-6/23/23, although there were medical concerns for the SS and mental health concerns for the parents. There was no casework activity from 3/3/23 to 4/4/23 and 4/6/23 to 6/6/23. The CPS investigation remained open at the time this report was written and a subsequent report was received on 6/22/23.

Was the decision to close the case appropriate? N/A

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

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:

The CPS investigation remained open at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The father of the 5yo SS was listed on the report; however, the record did not reflect he was

	contacted, or interviewed regarding the SCR report. The SS had regular contact with her father.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	Although the record reflected mental health concerns for the mother, father, and ongoing medical concerns for the 5yo SS, the family had not been seen from 2/15/23 to 6/23/23. There was no casework activity from 3/3/23 to 4/4/23 and 4/6/23 to 6/6/23. On 6/6/23, BCDSS was unable to contact the family, as the mother's phone was not in service.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	BCDSS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/11/2023 **Time of Death:** 12:58 PM (Approximate)

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

County where fatality incident occurred: Broome
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Other Household 1	Other Adult - Father of the 5yo SS	No Role	Male	25 Year(s)

LDSS Response

On 2/11/23, BCDSS received 2 reports regarding the death of the SC. BCDSS initiated their investigation within 24-hours and coordinated their efforts with LE. BCDSS contacted the sources of the reports, completed a CPS history check regarding the family, and informed the DA of the fatality. BCDSS conducted an initial home visit and assessed the safety of the SS.

BCDSS interviewed the adults and learned the SC had suffered from gastrointestinal issues and his formula had been changed several times. The parents reported ongoing concerns regarding the water in the home being brown, and that two of their dogs died within a week of the child's death. The parents reported using bottled water to feed the child; however, the parents ran out of bottled water and used tap water from the bathroom faucet to prepare the child's bottles. The parents reported the SC was irritable and fussy the day prior to his death. The mother said the SC was teething and she gave him a dissolvable oral pain relief tablet. On 2/11/23, at about 8:00AM the mother fed the SC, and then placed him in the bassinet wrapped in a blanket on his side, with a small pillow. Sometime between 9:00AM and 10:00AM, the mother checked on the SC, gave him a pacifier, and she went to sleep in another room. The father woke up between 12:00PM and 12:30PM, and went to check on the SC. The father found the SC in the bassinet unresponsive; he picked the SC up and he was cold and stiff. The father did not know what to do and yelled for the mother. The mother called 911, and the father held the SC until EMS arrived.

The SS was not home when the fatal incident occurred, she was visiting at her father's home. The SS had no information regarding the SC's death. BCDSS interviewed the SS and she appeared free from visible marks or bruises and was assessed as safe. The pediatrician reported the SS had ongoing ear, nose, and throat concerns and the SS was referred to a specialist. After the death of the SC, the SS was seen medically because of the concerns with the water in the home. The SS had a sore throat and fever and was provided with a follow-up appointment at the pediatrician; however, no other concerns were identified.

BCDSS contacted collateral sources, including EMS, LE, family members, and the pediatrician. The SC was last seen by his pediatrician on 1/2/23 regarding vomiting and constipation, his formula was changed, and he was referred to a gastroenterologist. The SC was a no-show for two appointments with the pediatrician during December 2022 and missed a recheck appointment on 1/26/23. The pediatrician had no concerns for the SS. The record reflected that BCDSS spoke with the health department and there were no concerns regarding the water. BCDSS offered the family bereavement services, and the family declined. BCDSS provided the family with a list of community-based resources. The SS was enrolled in counseling services at her school. The CPS investigation remained open at the time this report was written; therefore, a determination had not yet been made and the allegations were pending.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064241 - Deceased Child, Male, 3 Mons	064242 - Mother, Female, 26 Year(s)	DOA / Fatality	Pending
064241 - Deceased Child, Male, 3 Mons	064242 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
064241 - Deceased Child, Male, 3 Mons	064243 - Father, Male, 29 Year(s)	DOA / Fatality	Pending
064241 - Deceased Child, Male, 3 Mons	064243 - Father, Male, 29 Year(s)	Inadequate Guardianship	Pending

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?	☒	☐	☐	☐

Additional information:
The record did not reflect that BCDSS contacted or interviewed the father of the 5yo SS.

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:
The record did not reflect the family was offered burial assistance because there was a GoFundMe page. The parents were offered bereavement services and mental health counseling, and they declined. The SS was enrolled in counseling through school. The CPS investigation remained open at the time this report was written and the RAP had not been completed.

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?	☐	☒	☐	☐

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 the family was offered burial assistance due to there being a GoFundMe page. The family declined bereavement and mental health counseling. The family was referred to community-based services related to the fatality.

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:
BCDSS offered the mother services for the SS, and she declined. The mother enrolled the SS in counseling services through the school.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BCDSS offered the mother and father bereavement services and mental health counseling, and they declined. BCDSS

provided the parents with a list of community-based resources. The record did not reflect BCDSS offered the family burial assistance because a GoFundMe page was established.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/11/2020	Sibling, Female, 2 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 2 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 2 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Father, Male, 26 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - Father of the 5yo SS, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - Father of the 5yo SS, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the mother, father, and the other adult abused marijuana to the point of impairment while caring for the then 2yo SS. The drugs and paraphernalia were left accessible to the SS. It was unknown if the SS had been harmed as a result of the adults' actions.

Report Determination: Unfounded | **Date of Determination:** 05/19/2020

Basis for Determination:
The allegations of Inadequate Guardianship and Parent Drug/Alcohol Misuse against the mother, father, and the other adult regarding the then 2yo SS were unfounded. The investigation revealed there was no credible evidence the adults were impaired by marijuana while caring for the SS or that there was marijuana accessible to the SS. The case was unfounded and closed.

OCFS Review Results:
The record reflected timely completion of case objectives including the investigation initiation, 7-day Safety Assessment, provision of notification letters, and check of CPS history.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

In 2019, the 5yo SS was named as a maltreated child in an unfounded investigation with allegations of Inadequate Food, Clothing, and Shelter and Inadequate Guardianship against the mother and her biological father.

Known CPS History Outside of NYS

There was 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.

Additional Local District Comments

BCDSS disagrees with NYS OCFS's fatality investigation findings, specifically:

Failure to Conduct a Face-to-Face Interview: Surviving Sibling's (SS) father was notified of report(s) via Notice of Existence letter(s). A home visit and interview with SS father has been scheduled for 7/17/23; the required face-to-face interview will be complete prior to case closure.

Pre-Determination/Assessment of Current Safety/Risk: The case only remains open awaiting the autopsy report, not because of unresolved protective issues. While the record reflected presence of MH concerns for mother and father, there was no evidence of impact on child SS. Mother is under the care of a mental health professional for on-going support with her MH challenges. SS does have ongoing medical concerns. SS was assessed as receiving appropriate care by CW and medical personnel. Continued risk is not present. Unnecessary follow-up visits would result in additional trauma and over surveillance of this family.

Adequate Assessment of Family's Need for Services: The family refused identified service needs, specifically bereavement counseling and mental health counseling. Mother is under the care of a mental health professional for on-going support and medication adjustments if needed. The family was assessed not to need additional services.

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