Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-23-008

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

Issue Date: Jul 28, 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: 16 day(s)
Jurisdiction: St. Lawrence
Gender: Male
Date of Death: 02/13/2023
Initial Date OCFS Notified: 02/13/2023

Presenting Information

The SCR report alleged that during the night of 2/12/23, the subject child was placed to sleep in a bassinet, wearing a one-piece sleeper and covered with a blanket. On 2/13/23, around 4:00AM, the mother woke up and found the child cold and unresponsive in the bassinet. The mother woke the father, and the parents called 911. The parents attempted cardiopulmonary resuscitation (CPR) and noticed vomit in the child's mouth. They attempted to remove the vomit and a drop of blood came out of the child's nose. Law enforcement and emergency medical services (EMS) responded to the home. EMS determined the child was deceased. The child was an otherwise healthy child, and the parents had no explanation for his death. Additionally, there was clutter, garbage, and flies throughout the home, including in the bedroom where the bassinet and the 1-year-old sibling's bed was located. The toilet was allegedly full of feces and the kitchen had dirty dishes with stuck on dried food.

Executive Summary

This report concerns the death of the 16-day-old subject child. St. Lawrence County Department of Social Services (SLCDSS) received an SCR report regarding the child's death on 2/13/23. At the time of the child's death, he resided with his mother, father, and 1-year-old sibling.

On the evening of 2/12/23, sometime around 10:30PM, the mother, father, subject child, and sibling returned home from visiting friends and family. The sibling was laid down to sleep in the parents' bed and the subject child was placed in an infant swing while the mother cooked dinner. The mother then changed the child's diaper and handed him to the father for the father to feed the child a bottle. The mother noticed the father was dozing off while holding the child, so the mother took the child and placed him in his bassinet. The mother laid the child on his back and tucked a blanket around the child. The mother then watched television and fell asleep. She next woke around 4:00AM, thinking she heard a whimper. She checked on the child and noticed his lips "looked weird" and had a bit of blue coloring. She rubbed his chest and he felt cold. The child did not react to the mother's touch, so the mother picked him up and held him to her face. He was cold, not breathing, and unresponsive. The mother woke the father, handed the child to the father, and called the paternal grandmother for direction. The mother was advised to call 911, which she did. The father provided CPR as instructed by the 911 dispatcher until first responders arrived and took over life-saving measures. Life-saving efforts continued for 30 to 40 minutes with no change and the parents consented to a time of death being called at the home. The child was not transported to the hospital.

The coroner responded to the home and declared the death. The coroner hypothesized based on the state of the child when they arrived around 4:50AM, the death likely occurred not long after the child was put to bed. An autopsy was performed; however, SLCDSS had not yet received the final autopsy report at the time this report was written. Preliminary results did not show signs of abuse or maltreatment. Law enforcement attended the autopsy and reported findings showed nothing irregular, no signs of aspiration, and no signs of shaken baby syndrome. Per law enforcement, there was no conclusive cause of death at that time. Law enforcement investigated and had not filed any charges at the time this report was written and were waiting on the final autopsy report before closing their investigation.

SLCDSS made several home visits and interviewed the parents, extended family members and friends, all of whom had recent contact with the child. The sibling was assessed to be safe and remained in the care of his parents. The family relocated during the open investigation and SLCDSS assessed each residence.

The investigation had not yet been determined at the time this report was written. The mother and father accepted referrals for bereavement counseling and SLCDSS was coordinating relevant services with the parents' provider.

PIP Requirement

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

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:

The physical condition of the home was not reflected in the Initial Safety Assessment; however, progress notes adequately documented conversations with the parents regarding interventions put in place to protect the sibling from the hazards noted and the record indicated improvement by the subsequent Safety Assessment due dates.

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

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:

The CPS investigation remained ongoing, and SLCDSS continued to assess the sibling's safety and the family's service needs.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Multiple progress notes were not entered contemporaneously during the investigation, and some were documented over 30 days from the event date.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/13/2023 **Time of Death:** Unknown

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

County where fatality incident occurred: St. Lawrence
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	16 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)

LDSS Response

SLCDSS initiated their investigation within 24 hours and coordinated their efforts with LE. SLCDSS contacted the source of the report, completed a CPS history check on the family, and communicated with the DA regarding the fatality. SLCDSS assessed the safety of the sibling and conducted an initial home visit the same date the report was received.

SLCDSS interviewed the parents separately regarding the events leading up to the child's death. The mother provided a timeline of the day prior and noted nothing out of the ordinary. When the father finished work around 6:30PM, the family left to visit friends and the MGM. The family had gone to three different houses and retuned home around 10:30PM. The sibling had fallen asleep during the car ride home and the father laid him down in the parents' bed. The sibling did have a toddler bed available for use. The mother made dinner for herself and the father while the father fed the subject child a bottle and then placed the child in his swing while the parents ate. After their dinner, the mother brought the child into the parents' bedroom to change his diaper, then handed him to the father for the father to feed the child another bottle. The father was in bed with the child while feeding him and the mother noticed the father was dozing off, so the mother took the child from the father, burped the child, and laid the child in his bassinet which was in the parents' bedroom. The mother placed the child face up, with a blanket covering him from the waist down, and the blanket was coving the child's arms and tucked underneath him. The mother laid down to watch television and fell asleep. The mother was unsure of the exact time she fell asleep. She next woke up at 4:00AM because she heard what sounded like a whimper. She looked over to the sibling and could see him sleeping and heard him snoring. She then looked to the subject child and immediately noticed his lips "looked weird" and were colored blue. She rubbed his chest and felt coldness emanating from his body. The child did not react to the mother's touch. She picked the child up and held him near her face. He was cold, unresponsive, and not breathing. The mother immediately woke the father and told him the child was not breathing. She handed the child to the father. The mother panicked and called the PGM as she lived nearby and asked the PGM if she should go to the hospital or call 911 and the PGM directed the mother to call 911. The father placed the child on the couch while calling 911, and then moved the child to the floor as advised by the 911 dispatcher, who instructed the father on how to perform CPR. The parents observed vomit coming from the child's mouth, which the mother attempted to suction out. First responders arrived at the home and took over life-saving measures. Two AED devices were used, and CPR was attempted for 30 to 40 minutes with no signs of life. The parents were asked if they would like the child transported to the hospital for additional measures to be taken, or if they consented to calling a time of death. The parents consented to cease efforts and the coroner was notified.

SLCDSS learned the child was scheduled for a Dr. appointment 2/13/23 for a car seat tolerance test. According to the mother, the child was 5lbs 10.3oz at birth and "jittery." Releases of information were obtained for the birth hospital and pediatrician; however, the record did not reflect either collateral was contacted.

Upon initial contact, the home was found to be cluttered and in general decline; however, SLCDSS assessed that did not pose a safety hazard to the sibling. The cleanliness of the home was addressed with the parents, it was noted locked doors and baby gates were utilized to prevent access to unsafe areas, and the condition of the home improved up until the point the family relocated. SLCDSS continued to monitor the family through the ongoing CPS investigation at their new residence.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063978 - Deceased Child, Male, 16 Days	064008 - Mother, Female, 20 Year(s)	DOA / Fatality	Pending
063978 - Deceased Child, Male, 16 Days	064008 - Mother, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063978 - Deceased Child, Male, 16 Days	064008 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Pending
063978 - Deceased Child, Male, 16 Days	064009 - Father, Male, 21 Year(s)	DOA / Fatality	Pending
063978 - Deceased Child, Male, 16 Days	064009 - Father, Male, 21 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063978 - Deceased Child, Male, 16 Days	064009 - Father, Male, 21 Year(s)	Inadequate Guardianship	Pending
064010 - Sibling, Male, 1 Year(s)	064008 - Mother, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Pending
064010 - Sibling, Male, 1 Year(s)	064008 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Pending
064010 - Sibling, Male, 1 Year(s)	064009 - Father, Male, 21 Year(s)	Inadequate Food / Clothing / Shelter	Pending
064010 - Sibling, Male, 1 Year(s)	064009 - Father, Male, 21 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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: The RAP had not yet been completed as the investigation was ongoing. Service needs were identified throughout the open case and appropriate referrals were made.				

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:
Potential service needs around the parents' marijuana use were not explored. The parents were referred to multiple community-based services and had engaged in services during the open investigation. Due to a domestic incident between the paternal grandparents and the mother, the mother's mental health provider referred the parents to relevant services.

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? No
Explain:
No service need specific to the fatality was identified for the sibling; however, the parents were provided a plethora of community-based services to meet the family's needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother and father were referred to and engaged in counseling services, and they reported the counseling to be helpful. The MGM was receptive to a referral; however, it was not documented if one was ultimately completed or if she had engaged in services. All other family members declined bereavement referrals.

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 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