Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-23-014

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

Issue Date: Aug 16, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Broome
Gender: Male
Date of Death: 03/12/2023
Initial Date OCFS Notified: 03/12/2023

Presenting Information

The SCR report alleged on 3/12/23, between 12:00AM and 6:00AM, the mother and father were co-sleeping with the subject child in the parents' bed. The mother and father's bed was filled with several blankets and pillows. At one point, the subject child was on his stomach. While in bed with the mother and father, at an unspecified time, the subject child stopped breathing. At approximately 6:52AM, the mother discovered the subject child unresponsive, cold to the touch, and purple in the face. At this time, rigor mortis had set in. The mother promptly called emergency medical services who arrived and attempted life-saving measures on the subject child, however, at 6:57AM, the subject child was pronounced deceased. The report alleged the unsafe sleep conditions contributed to the subject child's death.

Executive Summary

This fatality reports concerns the death of the 1-month-old male subject child that occurred on 3/12/23. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the mother and father. At the time of his death, the subject child resided with the mother and father. There were no surviving siblings or children in the household.

Broome County Department of Social Services (BCDSS) completed casework and collateral contacts and learned that on 3/11/23, the subject child was given a bottle around 11:00PM. The subject child was placed in the center of the parent's queen-sized bed on a pillow. The mother laid on the right side of the subject child while the father laid on the left. Sometime after 6:00AM on 3/12/23, the father awoke to find the subject child unresponsive. The mother awoke to the father in distress and called the maternal grandmother. The grandmother advised the parents to hang up and contact 911, which they did so at that time. The father attempted cardiopulmonary resuscitation; however, then went outside to flag down emergency medical services. Life-saving measures were attempted by emergency medical services, but the subject child was pronounced deceased at the family's home.

An autopsy was performed, and the final cause of death was listed as sudden death associated with an unsafe sleeping environment and the manner was undetermined. The subject child's time of death was estimated to be between 1:00-5:00AM on 3/12/23, but the child had undigested food in his stomach which indicated the child was deceased closer to 1:00AM. The coroner reported the subject child appeared to be an otherwise healthy child. The status of the criminal investigation was unknown to this writer, but there were no criminal charges filed pertaining to the subject child's death.

Bereavement services were offered to the parents following the death of the subject child; however, it was unknown if the family had utilized or engaged in counseling services. The CPS investigation remained open at the time of this writing and therefore, the allegations of the report had not yet been determined.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The CPS investigation remained open at the time of this writing and therefore, no determination had been made.

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:
Casework 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: 03/12/2023 **Time of Death:** Unknown

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: 06:52 AM
Did EMS respond to the scene? Yes
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

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 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

Upon receipt of the SCR report, BCDSS coordinated their investigation with LE, interviewed the parents, completed a CPS history check, contacted collateral sources, and completed a home visit.

BCDSS interviewed the SM and SF and learned that on 3/11/23 the parents and SC went out with a family friend to the mall. The family returned to the home around 10:00PM. Around 11:00PM, the parents changed and fed the SC a 4-ounce bottle of formula. Around 11:45PM the family friend left the residence. The SC was in the middle of the parent's queen-sized bed on a firm pillow. The SM and SF denied there being any other pillows or blankets on or near the SC. The SC slept in a zip-up hoodie, onesie, and socks which the coroner stated was not appropriate sleep attire. The SM slept on the right side of the SC and the SF slept on the SC's left side. The SF woke up between 6:00-7:00AM and found the SC pale and cold. The SF stated the right side of the SC's face was black. The SF reported the SC was in the same position he was put to sleep in, face-up, but his head was a little higher on the pillow. The SF denied there were any blankets or pillows obstructing the SC's face, or that he saw any spit-up or blood on the SC. The SM called the MGM and was advised to call 911. The SM called 911 and the SF attempted CPR until he went outside to get EMS. EMS attempted resuscitation efforts, but the SC was in rigor mortis and pronounced deceased at the home. The family friend was interviewed and expressed no concern for the care of the SC by the parents, and stated the SC appeared happy and healthy. The MGM also had no concerns for the SC and assumed the SC slept in his bassinet.

The SC had various safe sleep provisions in the home including a bassinet, Pack n' Play, and crib; however, BCDSS and LE observed these to be filled with clothing and they appeared unused. During home visits, the SM and SF's bed was observed to have blankets, pillows, and clothing on it. The SM and SF reported regularly co-sleeping with the SC. Pediatrician records reflect that safe sleep guidelines were reviewed with the SM and SF, but the parents reported being told by the pediatrician to put the SC on a firm elevated pillow. The record did not reflect that this was discussed with the pediatrician. The SM and SF reported they bought a new, firmer pillow for the SC that day while they were out. The record did not reflect that BCDSS discussed safe sleep recommendations with the parents.

The SF reported the SC vomited a lot 2 days prior to his death but had not since. The SM and SF reported the SC was constipated and they gave him gas drops and diluted apple juice. The SM denied being advised to do this, stating she just knew it helped constipation and it was very diluted. The SM reported giving the SC apple juice on one or two occasions.

The SC was seen by his pediatrician on 2/28/23 where it was noted the SC's belly button was spot bleeding and the SC had not had a bowel movement in 3 days. The SC was also diagnosed with Thrush and prescribed an antifungal, which the SF stated the SC was receiving as prescribed. The SC was jaundiced and slow to feed at the time of his birth but had no other noted medical concerns.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical cause

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
Comments: Broome County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064586 - Deceased Child, Male, 1 Mons	064587 - Mother, Female, 19 Year(s)	DOA / Fatality	Pending
064586 - Deceased Child, Male, 1 Mons	064587 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Pending
064586 - Deceased Child, Male, 1 Mons	064588 - Father, Male, 21 Year(s)	DOA / Fatality	Pending
064586 - Deceased Child, Male, 1 Mons	064588 - 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?	☒	☐	☐	☐
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:
Bereavement services were offered to the parents following the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Bereavement services were offered to the mother and father; however, the parents were not yet engaged in counseling services at the time of this writing.

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

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 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 agrees with NYS OCFS' fatality investigation findings, that BCDSS casework and supervisory oversight of this fatality was appropriate and compliant with relevant statutory and regulatory requirements.

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