Child Fatality Report

Report Identification Number: SY-23-024

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

Issue Date: Oct 03, 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: 4 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 05/01/2023
Initial Date OCFS Notified: 05/01/2023

Presenting Information

Multiple SCR reports were received on 5/1/23, that alleged the subject child was found unresponsive in his crib by the mother and was bleeding from his mouth. The mother picked the subject child up and placed the child on her bed and called 911. The subject child was an otherwise healthy child, and the mother had no explanation for his death.

Executive Summary

This fatality report concerns the death of the 4-month-old male subject child that occurred on 5/1/23. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the mother. At the time of his death, the subject child resided with his mother. There were no surviving children or siblings in the deceased child's household. The putative father resided in a separate residence, was not aware he was the father of the subject child, and had not met him. The putative father had a 6-year-old child.

Onondaga County Department of Children and Family Services (OCDCFS) completed casework and collateral contacts and learned that on 4/31/23, the mother placed the subject child to sleep on an infant co-sleeper on top of her adult-sized bed. The mother awoke around 9:30AM on 5/1/23 and found the subject child felt "hard" and unresponsive. The mother attempted cardiopulmonary resuscitation; however, was unsuccessful. The mother called 911 and emergency medical services responded to the home. Life-saving measures were attempted, but the subject child was pronounced deceased in the home.

An autopsy was completed, and the final cause of death was Corona (COVID-19) Viral Infection, and the manner was natural. The medical examiner noted no injuries to the subject child, but the child was discovered to have pulmonary congestion, pus within the thymus, cerebral vascular congestion, early signs of pneumonia, small clots on the kidneys, and he had a positive nasopharyngeal swab for the COVID-19 virus. The status of the law enforcement investigation was unknown; however, no charges had been filed related to the subject child's death.

Bereavement services were offered to the mother and putative father. OCDCFS was made aware the putative father had a 6-year-old child. Although OCDCFS made diligent efforts to meet with this child face-to-face, the investigation revealed concerns regarding the putative father's discipline of this child that were not fully explored to determine if these concerns posed a risk to the safety of the child. The allegations of the CPS investigation were unsubstantiated against the mother due to the findings in the autopsy. The medical examiner stated while the sleeping environment was not ideal, asphyxia due to overlay was unlikely. The CPS investigation was unfounded and closed on 8/10/23.

PIP Requirement
This review resulted in a citation related to casework practice. In response, OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDCFS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDCFS will review the plan(s) and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
OCDCFS made an appropriate determination based on the evidence obtained during their investigation.

Was the decision to close the case appropriate? Yes

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

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

Explain:
Casework was not commensurate with case circumstances. OCDCFS was made aware of possible concern regarding the putative father's child; however, the record did not reflect that these concerns were fully explored or addressed to determine if there was a safety concern regarding that child.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	OCDCFS was made aware of concerns regarding the putative father's discipline of his 6yo child; however, the record did not reflect this was fully explored or addressed with the father to determine if there were safety concerns for that child.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. OCDCFS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/01/2023 **Time of Death:** 09:37 AM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 09:30 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	4 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDCFS coordinated their investigation with LE, interviewed the mother, completed a CPS history check, and contacted collateral sources.

OCDCFS interviewed the SM and learned that on 4/31/23, the SM went out with friends while the SC was watched by the MGM and MGF. The SM picked the SC up from the MGM's home around 5:30PM. The SC fell asleep on the way home and upon arrival home, the SM put the SC on the couch. Around 10:30PM, the SM fed the SC and put him to sleep for the night. The SM put the SC on an infant co-sleeping bed on top of her bed. The co-sleeping bed was described as a "small cushion made for a baby" but it appeared very soft. The SM placed the SC on his back, with a pacifier, and covered him just above his stomach with a blanket. The SM stated the SC was strong enough to pull off the blanket. The SM woke up at 9:30AM and found the SC in the same position. The SM went to say good morning to the SC and noticed he was "hard." The SM stated she knew something was wrong and attempted to rub the SC's chest; however, he did not respond. The SM picked the SC up and blood came out of his nose and mouth. The SM attempted CPR but was unsuccessful. The SM called 911 and EMS responded to the home. Life-saving efforts were unsuccessful, and the SC was pronounced deceased in the home.

EMS reported there was blood on the SM's bed as well as a body pillow on the bed, and noted the SC's crib appeared unused.

The MGM and MGF were interviewed and reported no concerns for the SM's care of the SC. The MGM and MGF did not notice any signs of illness or distress in the SC on the day preceding his death, noting the SC appeared happy and smiling. Other collateral sources noted no concerns for the SC. The putative father was interviewed but was unaware he was the father and had no contact with the SC, and therefore, did not have information related to the fatal incident.

The SM noted the SC had been sneezing in the days preceding his death; however, the SM was house-sitting at a home that had cats and assumed the SC had an allergy to the cats, as the SM did too. The SM also reported the SC had a "different" bowel movement but denied being aware of the SC being exposed to anyone who was sick or had COVID-19. The SM noted the SC did not interact with many other people, aside from his babysitter. The record did not reflect contact was made with the SC's babysitter.

The SC last saw his pediatrician on 4/14/23 and was up to date on immunizations, with no other medical concerns noted. The SC's pediatrician confirmed safe sleep guidelines were reviewed with the SM.

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: Onondaga 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
064782 - Deceased Child, Male, 4 Mons	064783 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
064782 - Deceased Child, Male, 4 Mons	064783 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☒	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐

Caretakers / Babysitters	☐	☒	☐	☐
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 OCDCFS contacted the SC's babysitter, despite their caretaking role for the SC. OCDCFS made attempts to assess and interview the putative father's child; however, were unsuccessful.

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 and burial assistance were offered to the mother and putative father; however, it was unknown if services were utilized.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
Bereavement services were offered to the mother and putative father, but it was unknown if services were being utilized.

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.

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