Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-24-037

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

Issue Date: Feb 04, 2025

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: 6 month(s)
Jurisdiction: Jefferson
Gender: Male
Date of Death: 08/09/2024
Initial Date OCFS Notified: 08/09/2024

Presenting Information

On 8/9/24, at approximately 9:10AM, the father checked on the 6-month-old subject child who was in his crib. The subject child was found unresponsive, on his back, and warm. The subject child shared a crib with his twin brother, and a large boppy pillow was in the crib taking up most of the space. At approximately 9:20AM, the father contacted a family member, and the family member contacted emergency services. At 9:25AM, law enforcement arrived at the home and started CPR, noting the subject child's skin was blue. Shortly after, EMS arrived at the case address and transported the subject child to the hospital where life-saving measures continued. At approximately 10:03AM, the subject child was pronounced deceased. It was suspected the unsafe sleep environment contributed to the subject child's death.

Executive Summary

This fatality report concerns the death of the 6-month-old male subject child that occurred on 8/9/24. Jefferson County Department of Social Services (JCDSS) received the subsequent fatality report on that same date; the report included allegations of DOA/Fatality, Inadequate Food/Clothing/Shelter, Inadequate Guardianship, Lacerations/Bruises/Welts, and Lack of Supervision. At the time of his death, the subject child resided with his mother, father, and four surviving siblings aged 4 years, 1 year, 1 year, and 6 months.

The fatality report was subsequent to a report received on 4/3/24. The initial report had concerns that the home was a fire and safety hazard due to the conditions present, which included an accumulation of garbage blocking exits and causing the porch connected to the home to collapse. The initial report included allegations of Inadequate Food/Clothing/Shelter against the mother and father. A Preventive Services case was opened on 7/5/24 in an effort to assist the family financially with obtaining a dumpster to improve the conditions of the home.

On 8/9/24, while the mother was at work, the father checked on the subject child and found him unresponsive in his crib. The father was unable to contact 911 directly due to not having a phone; however, he was able to contact the mother using a tablet. The mother called the maternal grandmother who flagged down law enforcement and got a ride to the case address. Law enforcement contacted EMS and directed the father on how to perform CPR while on route to the home; law enforcement took over life saving measures upon arrival. EMS transported the subject child to the hospital where life-saving efforts continued; however, were unsuccessful. The subject child was pronounced deceased at 10:03AM. While in the home, law enforcement observed multiple concerns regarding the safety and hygiene of the home environment.

JCDSS communicated with law enforcement and learned there were multiple concerns regarding the condition of the home environment. In addition, hospital staff observed the subject child to appear “mottled and emaciated in appearance, with a distended stomach and fixed pupils.”

Following the fatality a safety plan was implemented for the surviving siblings, and they received a medical assessment. The SSs were observed to have small marks and bruises on their bodies, including a linear bruise on the 4yo SS’s buttock. Dime sized bruises observed on the 6mo SS were determined to inconsistent with his developmental age, however, the caregivers reported they were likely caused by the 1yo SS being too rough with him. The case record does not reflect that the parents were questioned by JCDSS regarding the linear bruise on the 4yo SS, nor was the MGM interviewed

regarding the SS's marks and bruises. The siblings stayed with the maternal grandmother until it was determined she would be added to the report as a subject. This decision was made due to the maternal grandmother's knowledge of the inner workings of the home, her regular presence there, and failure to act on behalf of the children. The surviving siblings were placed in respite care on 8/13/24, and a neglect petition was filed in Family Court. On 8/20/24, the mother and father consented to the surviving siblings being placed in foster care. Orders of protection were issued against the parents in favor of the surviving siblings. In addition, the parents were ordered to complete services. On 11/12/24, the mother and father were criminally charged with 5 counts of Endangering the Welfare of a Child.

JCDSS communicated with the medical examiner and learned the cause of death was Sudden Unexplained Infant Death Syndrome with extrinsic and intrinsic factors; the manner of death was undetermined. The autopsy report stated the child was a normal, small infant that was placed in an unsafe sleep environment. Genetic testing revealed the subject child had genetic mutations present that were associated with an undiagnosed medical condition. It was noted the positive genetic test was of uncertain significance.

The mother and father regularly attended supervised visitation with the surviving siblings and engaged in court ordered services. Services included parenting and life skills classes, individual counseling, a reunification program, and psychological testing. Bereavement referrals were offered to the family and accepted, however, there was no documentation in case record of offers of burial assistance. The investigation was closed, and the foster care case remained open. The father was indicated for DOA/Fatality and Lack of Supervision in regard to the subject child; the mother, father, and maternal grandmother were substantiated for Inadequate Guardianship and Inadequate Food/Clothing/Shelter. Allegations of Lacerations/Bruises/Welts were unsubstantiated.

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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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:
There was no documentation in the case record of JCDSS interviewing the SM, SF, or MGM regarding the linear bruises observed on the 4yo SS. There was no record of the MGM being questioned in regard to the bruising observed on the 6-month-old SS. The RAP was incorrectly scored for several risk elements; however, the casework practice issue was cited in a separate historical investigation and will not be cited again.

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:	During the investigation, the 4yo SS was found to have linear bruising on her buttock, and the 6-month-old SS was found to have dime sized bruises present on his head. A medical assessment deemed these marks suspicious. The caregivers had no concrete explanation for the 6-month-old SS's injuries; the SM and SF suggested an older sibling could have been too rough with him. This demonstrated the SSs were not competently attended, which resulted in the children sustaining injuries. Further evidence was revealed when the SF stated he does not attend to the children when he is playing his video games if he is unable to pause the game. Despite this information, there were no additional L/B/W allegations added/substantiated against the caregivers in regard to the 4yo and 6-month-old SSs, nor were allegations of LS added/substantiated against the SF in regard to all SSs.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	In addition to conditions enumerated in the report, CPS is required to determine any other condition that may constitute abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/09/2024 **Time of Death:** 10:03 AM

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

County where fatality incident occurred: Jefferson
Was 911 or local emergency number called? Yes
Time of Call: 09:19 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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	46 Year(s)

LDSS Response

On 8/9/24, JCDSS received an SCR report regarding the death of the SC. JCDSS initiated the investigation within 24 hours and coordinated efforts with LE. The source was spoken to, the DA was contacted, and relevant collateral contacts were made. The SSs were assessed medically and found to have bruises on their body that the SM and SF could not account for. The 4yo had a linear bruise on her buttock, and the 6-month-old SS had bruising present on his head that was inconsistent with his developmental age. Once cleared, the SSs were transported to a respite foster home.

LE observed the home and found the crib where the SC was sleeping contained a ripped double Boppy pillow with stuffing coming out, a loose bed sheet, a metal hanger, a pack of diapers, clothing, mouse feces, and human feces and urine stains. A deceased kitten was found under the crib, and animal feces were observed throughout the home. The SSs were described as “dirty,” and running through the feces in the home. There was an accumulation of garbage and personal items around the home.

The SF provided conflicting stories when interviewed by LE and CPS. Initially, the SF stated to LE that he gave the SC a bottle around 1:30AM-2AM, before putting him back in the crib to sleep. The SF was up at 6:30AM making the SSs breakfast and had woken up the SC, leaving him in the crib watching a cartoon. When he returned 15 minutes later, he found the SC unresponsive; the subject child had blue lips and was warm on his back in the Boppy pillow.

When the SF was interviewed by CPS, he stated he went to bed at 2:30AM and was up at 6:30AM. After completing some tasks for the SSs, he went to get the SC from his crib. When he entered the room, he found the SC rested against the Boppy pillow with his eyes open, and not breathing. The SF stated the SC was warm, however, the SF explained the heat was set to 90 degrees to warm up the room after the air conditioner was on all night.

The SM stated she was at work when the incident occurred. The SM’s shift started at 8PM on 8/8/24, and she was

scheduled until 9AM on the day of the incident. The SM received a phone call from the SF regarding the unresponsive SC and contacted the MGM. In the SM's statement with LE, she stated she left work at 9AM and checked the cameras that were present in the living room of the home. The SM stated she observed the SF sleeping, then watched him get out of the bed and go into the SC's room. She then observed the SF running frantically around the living room looking for the tablet to contact the SM. The SM stated when they connected on the tablet, she learned the SC was unresponsive and the SF told her to "get home right now." The SM then contacted the MGM. It was unknown why the SM did not contact 911.

The SM and SF disclosed mental health diagnoses which they no longer received treatment for, and that they regularly smoked marijuana. The caregivers stated they were educated on safe sleep during every home visit conducted by CPS; however, they continued to have the SC, and his twin brother sleep together in the crib with the Boppy pillow. The SM and SF stated the SC was alone in the crib when the incident occurred; the 6-month-old SS was sleeping in a Rock and Play in the living room. When questioned, the caregivers stated the other items found in the crib were "an oversight."

LE and CPS had concerns regarding the SF's gaming, which he stated he played 8-10 hours a day, including during times when he was the sole caregiver of the children. The SF admitted he sometimes had to wait until he could pause his game to attend to the needs of the children.

LE was interviewed and stated when they arrived on the scene, they met the SF outside and observed the SC to be blue. LE took the SC from the SF and continued life-saving measures until EMS arrived. While in the home, LE observed the home to be unsanitary and cluttered with items and garbage. LE noted the MGM made a comment regarding how she, "should have called CPS."

When the MGM was interviewed during the initial report, she stated she had no concerns. The MGM had regular weekly contact with the family and often brought the children to her home for overnights. During the fatality investigation, it was revealed the MGM had concerns regarding the cleanliness of the home and the SF's gaming. The day of the incident, the MGM stated she received a phone call from the SM who stated the SC was in duress. The MGM left her place of employment and flagged down LE. The MGM got a ride to the case address with LE and contacted the SF on the tablet while on route to the home. During this call, the officer providing transportation educated the SF on how to perform CPR. The MGM stated there were times when she was at the case address where she observed urine and feces on the floor. The MGM stated she wanted to help the SM and SF more but wanted them to learn "how to ask for help."

The ER doctor was interviewed and stated the SC arrived via EMS and life-saving measures were continued. The SC was reportedly found at 9AM, had a large soft spot, fixed pupils, and an extended stomach. The SC had two marks on the base of his skull, which the doctor believed to be birthmarks. The ER nurse stated there were no suspicious marks or bruises observed on the SC, who arrived in a diaper so full "it was about to burst," and was "emaciated."

The SC had been seen by his pediatrician for his 4-month well-child checkup where it was noted he lost weight; however, he was not overly concerned. The pediatrician stated, "they [the family] have been a bit chaotic," and stated he was not surprised to hear about the home being dirty and unkempt.

The SSs were present in the home during the incident; however, the 4-year-old SS was asleep, and the other siblings were too young to interview.

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: 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: The fatality was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069278 - Deceased Child, Male, 6 Month(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069281 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069280 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
069278 - Deceased Child, Male, 6 Month(s)	069281 - Father, Male, 25 Year(s)	Lack of Supervision	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069281 - Father, Male, 25 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
069278 - Deceased Child, Male, 6 Month(s)	069280 - Mother, Female, 25 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
069278 - Deceased Child, Male, 6 Month(s)	069281 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069281 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069280 - Mother, Female, 25 Year(s)	Lack of Supervision	Substantiated
069278 - Deceased Child, Male, 6 Month(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
069279 - Sibling, Male, 6 Month(s)	069281 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069279 - Sibling, Male, 6 Month(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
069279 - Sibling, Male, 6 Month(s)	069281 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

069279 - Sibling, Male, 6 Month(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
069279 - Sibling, Male, 6 Month(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069279 - Sibling, Male, 6 Month(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069282 - Sibling, Female, 3 Year(s)	069281 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069282 - Sibling, Female, 3 Year(s)	069281 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069282 - Sibling, Female, 3 Year(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
069282 - Sibling, Female, 3 Year(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069282 - Sibling, Female, 3 Year(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069282 - Sibling, Female, 3 Year(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
069283 - Sibling, Male, 1 Year(s)	069281 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069283 - Sibling, Male, 1 Year(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069283 - Sibling, Male, 1 Year(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069283 - Sibling, Male, 1 Year(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
069283 - Sibling, Male, 1 Year(s)	069281 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069283 - Sibling, Male, 1 Year(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
069284 - Sibling, Female, 1 Year(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
069284 - Sibling, Female, 1 Year(s)	069280 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069284 - Sibling, Female, 1 Year(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
069284 - Sibling, Female, 1 Year(s)	069281 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069284 - Sibling, Female, 1 Year(s)	069281 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069284 - Sibling, Female, 1 Year(s)	069475 - Grandparent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

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?	☒	☐	☐	☐
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:
Appropriate services were offered to the family.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
A neglect petition was filed in family court and the SM and SF consented to foster care placement.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
08/19/2024	There was not a fact finding	Care/Custody to Local Social Services District

Respondent:	069280 Mother Female 25 Year(s)
Comments:	An Article 10 neglect petition was filed in family court on 8/19/24, and the first appearance was 8/20/24. The caregivers consented to foster care placement, and orders of protection were issued against the SM and SF in favor of the SSs.

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/19/2024	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	069281 Father Male 25 Year(s)	
Comments:	An Article 10 neglect petition was filed in family court on 8/19/24, and the first appearance was 8/20/24. The caregivers consented to foster care placement, and orders of protection were issued against the SM and SF in favor of the SSs.	

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
11/12/2024	The Mother	Unknown	Unknown
Comments:	The mother was charged with five counts of Endangering the Welfare of a Child.		

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
11/12/2024	The Father	Unknown	Unknown
Comments:	The father was charged with five counts of Endangering the Welfare of a Child.		

Have any Orders of Protection been issued? Yes	
From: 08/20/2024	**To:** Unknown
Explain: Orders of protection were granted between the surviving siblings and the mother and father.	

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☒	☐
Preventive Services	☒	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? No
Explain:
Due to the age of the surviving siblings, there were no bereavement services offered on their behalf. Early Intervention services were offered and accepted.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
Bereavement services were offered to the SM, SF, and MGM in response to the fatality.

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
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco

- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ 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)
04/03/2024	Sibling, Male, 1 Years	Mother, Female, 25 Years	Burns / Scalding	Substantiated	Yes
	Sibling, Male, 1 Years	Father, Male, 24 Years	Burns / Scalding	Substantiated	
	Deceased Child, Male, 2 Months	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Months	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 3 Years	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2 Months	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Months	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 3 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2 Months	Grandparent, Female, 45 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Months	Grandparent, Female, 45 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Grandparent, Female, 45 Years	Inadequate Guardianship	Substantiated	

Sibling, Male, 1 Years	Grandparent, Female, 45 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 3 Years	Grandparent, Female, 45 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 2 Months	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 2 Months	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 1 Years	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 1 Years	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 3 Years	Mother, Female, 25 Years	Inadequate Food / Clothing / Shelter	Substantiated
Deceased Child, Male, 2 Months	Father, Male, 24 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 2 Months	Father, Male, 24 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 1 Years	Father, Male, 24 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 1 Years	Father, Male, 24 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 3 Years	Father, Male, 24 Years	Inadequate Food / Clothing / Shelter	Substantiated
Deceased Child, Male, 2 Months	Grandparent, Female, 45 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 2 Months	Grandparent, Female, 45 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 1 Years	Grandparent, Female, 45 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 1 Years	Grandparent, Female, 45 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 3 Years	Grandparent, Female, 45 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 1 Years	Mother, Female, 25 Years	Lack of Supervision	Substantiated
Sibling, Male, 1 Years	Mother, Female, 25 Years	Lack of Supervision	Substantiated
Sibling, Male, 1 Years	Father, Male, 24 Years	Lack of Supervision	Substantiated
Sibling, Male, 1 Years	Father, Male, 24 Years	Lack of Supervision	Substantiated

Report Summary:
The SM and SF have failed to provide the children with safe housing which resulted in the living conditions presenting a fire hazard. There was accumulated garbage present outside the home which made the one entry/exit point to the home nearly inaccessible. The deck on the back of the home is caving in, and there is an abundance of garbage and clutter in the home and on the bed. The subsequent reports were received while this investigation was open, which related to the death of the SC.

Report Determination: Indicated | **Date of Determination:** 08/28/2024

Basis for Determination:
An accumulation of garbage was present outside the home resulting in a single entry/exit point with restricted access and the deck on the back of home beginning to collapse. The interior of the home had garbage and clutter present throughout. The 1yo SS received 2nd degree burns when he pulled a pot of hot water off the stove which required medical care.

OCFS Review Results:
It was documented in the case record multiple times that the case would be unfounded once the dumpster was received, and the trash removed from the residence. The SM and the SF were also informed by workers that the case would be unfounded. It is unclear why allegations of LSUP were only added for the two 2yo SSs. The case record stated a home visit was conducted on 8/8/24 and the home was described as "clean and appropriate." However, the following day the home was observed by LE to have animal feces throughout, including in the SC's crib, which contained multiple items that did not follow safe sleep guidelines.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP was incorrectly scored for the following risk elements: For #6, the caretakers had and used reliable constructive support and assistance, was marked 'yes.' However, the MGM, whom the family used for support, was added to the investigation as a subject and the allegations were substantiated. Risk element #13 was marked 'yes,' that the caretakers had developmentally appropriate expectations of the children. The SM and SF were educated regarding safe sleep at every home visit; however, caretakers continued to put the children in unsafe sleep environments. Additionally, in the elevated risks section it was marked 'no' for serious physical injury to a child in the last six months due to abuse/maltreatment of a child. The 1yo SS received emergency medical treatment for 2nd degree burns due to the parents' lack of supervision.

Legal Reference:

18 NYCRR 432.2(d)

Action:

JCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

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.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 07/05/2024

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐

If not, how many days was it overdue?
The current FASP was 21 days overdue.

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
Preventive services were provided by JCDSS in conjunction with a voluntary agency.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was completed 21 days late.
Legal Reference:	18 NYCRR428.3(f)
Action:	JCDSS will complete timely and accurate FASPs.
Issue:	Failure to Complete a Plan Amendment
Summary:	A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case and direct a reassessment so that any necessary revisions to the service plan can be made.
Legal Reference:	18 NYCRR 428.7
Action:	JCDSS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

On 7/5/24, a Preventive Services case was opened to financially assist the family with acquiring a dumpster to get the home to minimum standards. JCDSS documented in the initial investigation that the plan was to assist the family with trash removal before the case was closed and unfounded. However, when the subject child passed on 8/9/24, the case remained open, and the surviving siblings were removed and placed in foster care.

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

The Respite parent picked the children up from the hospital not MGM. RAP- paternal gma was a source of support for the family as well-different from mgm/subj.
We attempted to make adjustments to the allegations but were not allowed by the system.

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