Child Fatality Report

Report Identification Number: SY-24-046

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

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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: 1 month(s)
Jurisdiction: Jefferson
Gender: Male
Date of Death: 11/03/2024
Initial Date OCFS Notified: 11/03/2024

Presenting Information

An SCR reported received on 11/3/24 alleged that the night prior, 11/2/24, at approximately 11:00PM, the mother laid down for bed with the 1-month-old subject child on one side of her and the sibling on the other side. At some point during the night, the mother allegedly rolled onto the child while sleeping. The mother woke up at 6:00AM on 11/3/24 and found the child unresponsive. The mother called 911 and the child was transported to the hospital. The child was pronounced deceased at 6:48AM. A second report was received that same day with substantively similar allegations and alleged the unsafe sleep situation contributed to the child's death.

Executive Summary

This report concerns the death of the 1-month-old male subject child. Jefferson County Department of Social Services (JCDSS) received two SCR reports regarding the death on 11/3/24. At the time of the child's death, he resided with his mother, father, and 2-year-old sibling.

On 11/2/24, the family had a "normal day" and was home. In the evening, after dinner, the family laid down to watch a movie. The father fell asleep shortly after the movie began. The mother remained awake throughout, and woke the father around 10:50PM so he could get ready for his overnight shift. The father left for work about 11:00PM. After the mother changed the child, the mother laid down in bed with both the subject child and sibling. The sibling was on the left side of the mother, and the subject child was on her right. The mother stated she was "usually" good about using the bassinet with the child and was tired that night. The father returned home briefly from work around midnight, as he left something behind. The father attempted to wake the mother but was unable. "They were all fine in the bed," and the father left. The mother next woke around 6:00AM the morning of 11/3/24 and observed the child "was passed away in my arm." The child was half blue and had bubbles in his nose. The mother called 911 and tried patting the child's back, and he was cold to the touch. The child was taken by ambulance to the hospital, where he was pronounced deceased at 6:48AM. The father was notified of the emergency and returned home shortly after the child was transported to the hospital.

The medical examiner was notified and performed an autopsy on the child. The cause of death was "sudden death associated with unsafe sleeping environment" and "rhinovirus." The manner of death was undetermined. Law enforcement was notified of the death and the status of their investigation was unknown; however, no arrests had been made in relation to the death.

JCDSS made several home visits and interviewed the parents. The sibling was assessed to be safe in the parents' care. Sleeping arrangements were discussed and the parents worked to transition the sibling into her own bed and room prior to case closure.

JCDSS substantiated all allegations and indicated the report. It was learned the mother used marijuana on 11/2/24, around 7:30PM, prior to bedsharing with the children and becoming the sole caretaker to the children when the father left for work. A drug screen completed on 11/3/24 was positive for a high level of marijuana. The mother was admittedly tired and slept through the father stopping by the house. JCDSS assessed this caused concern for her ability to effectively parent in an emergency. The subject child subsequently passed away in an unsafe sleep environment with aggravating factors present. The father was aware the mother had used marijuana earlier in the evening and knew she would be the

sole caretaker while he was at work. Additionally, the father was aware of the sleep setting, as he returned home and observed the bedsharing and did nothing to rectify the unsafe sleep environment.

The family accepted referrals for bereavement services. While the mother had re-engaged in mental health services with a previously established clinician, the father had yet to engage.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes

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 family was referred to community-based providers. The mother was engaged, though the father was not at closing. Preventive services were not explicitly offered, but the family denied needing any additional services from JCDSS.

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: 11/03/2024 **Time of Death:** 06:48 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: 06:06 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	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)

LDSS Response

On 11/3/24, JCDSS received two SCR reports regarding the death of the subject child. JCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement, who had already interviewed the parents prior to JCDSS's involvement. Both sources were contacted, and a CPS history check regarding the family was completed, revealing no prior CPS history. JCDSS reached out to the DA, who had been informed of the fatality by law enforcement. A home visit was completed the same day the reports were received, and the safety of the sibling was assessed immediately.

JCDSS interviewed the parents regarding the events leading up to the child's death. Both, separately, reported similar accounts. Nothing out of the ordinary was reported on 11/2/24; the family was home, and the child ate and napped without concern. After dinner, around 6:00PM, the family laid down to watch a movie. The father reported falling asleep about 10-15 minutes into the movie. The father worked overnight shifts and had work later that evening. The mother reported she remained awake throughout the movie and later reported she smoked marijuana around 7:30PM. The family remained in

bed until the father got up to get ready for work, around 10:50PM. The father left around 11:00PM, and the mother believed she fell asleep around 11:30PM. The mother fell asleep with both children in bed with her, the subject child to her right, and the sibling on her left. It was typical to bedshare with the sibling and there were differing accounts of the regularity of bedsharing with the subject child, but there was a bassinet available to the child. The father returned home briefly around midnight and observed the mother and children in the bed. The father tried to wake the mother and was unsuccessful, stating the mother slept “heavy.” The father reported always checking the subject child’s nose to ensure he was breathing. “They were all good,” and the father left. In hindsight, the father grieved, “I should have put [the child] in his bassinet,” but it was normal for the child to be in bed with the mother to ease with feeding. The child usually woke at midnight and again at 5-6:00AM, but that night, the mother did not wake until 6:00AM, at which time she observed the child half blue in color with bubbles in his nose. The mother called 911 and the father.

Emergency medical services responded and immediately initiated cardiopulmonary resuscitation. Orange milky fluid came out, which was explained as a typical response to fluid sitting in the airway that then comes up when chest compressions are started. The child’s pupils were fixed and dilated, with no response to light. His limbs were flaccid, and his skin was cold, mottled, pale, and cyanotic, and he was without a pulse. The child remained unresponsive and asystole enroute to the hospital. On arrival at the hospital, the child had rigor mortis, indicating death occurred several hours ago. CPR was halted and the child was pronounced dead. There were no signs of bruises or other injuries to the child.

JCDSS received the autopsy report, which indicated the death was associated with an unsafe sleeping environment and that the environment (in the mother’s arm, in an adult-sized bed) was concerning for accidental suffocation or overlay; however, the manner was undetermined.

JCDSS contacted numerous collaterals, including law enforcement, medical staff, the ME, first responders, family members, mental health, and the children’s pediatrician. The mother re-engaged with a previously established mental health provider. The father was initially agreeable to services but had not yet engaged at the time the case was determined and closed. Sleeping arrangements were discussed with the family, and at the close of the investigation the sibling was assessed to be safe in her parents’ care and was sleeping in her own bed, in her own room.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: From an injury - external 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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070381 - Deceased Child, Male, 1 Month(s)	070383 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated

070381 - Deceased Child, Male, 1 Month(s)	070382 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
070381 - Deceased Child, Male, 1 Month(s)	070382 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
070381 - Deceased Child, Male, 1 Month(s)	070382 - Mother, Female, 23 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
070384 - Sibling, Female, 2 Year(s)	070382 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
070384 - Sibling, Female, 2 Year(s)	070382 - Mother, Female, 23 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
070384 - Sibling, Female, 2 Year(s)	070383 - Father, Male, 25 Year(s)	Inadequate Guardianship	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	☒	☐	☐	☐

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 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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
Both parents agreed to referrals for grief counseling, mental health, and substance use assessments (both parents had a history of use and current marijuana use, and the father recently self-reported stopping alcohol use). The mother had a previously established provider she re-engaged with. While agreeable to referrals, the father had not engaged in any services prior to case closure.

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:
The sibling was 2 years old and did not demonstrate an understanding of the child's death nor did she display behaviors that would warrant a service referral.

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 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