Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-24-035

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: Steuben
Gender: Male
Date of Death: 12/26/2024
Initial Date OCFS Notified: 12/26/2024

Presenting Information

An SCR report was received on 12/26/24, which alleged that at approximately 5:30AM, the father checked on the 6-week-old while he was swaddled and sleeping in a Pack 'N Play. The father fed the child, and the child had a faint whimper. The father swaddled the child tighter and put him back into the Pack n' Play. The father checked on the child again at approximately 9:00AM and the child's eyes were half open, and the child was not reacting to anything. The father swaddled the child again and put him back in the Pack 'n Play. At approximately 10:00AM, the father checked on the child who was not moving. The parents transported the child to the hospital and arrived at approximately 11:11AM with a low heart rate and low temperature. Hospital staff performed cardiopulmonary resuscitation (CPR) upon arrival. The child was pronounced deceased at 12:08PM. The child was an otherwise healthy child, and the mother and father did not have an explanation for the child's death.

Executive Summary

This report concerns the death of a 1-month-old subject child. Steuben County Department of Social Services (SCDSS) received an SCR report regarding the subject child's death on 12/26/24. The report alleged that the subject mother and subject father failed to seek urgent medical care for the subject child by driving over an hour to a hospital while there was a closer hospital 20 minutes from the home. The parents failed to contact 911. Upon arrival at the emergency department, the subject child presented with a low heart rate and low body temperature. Life-saving measures were administered on the subject child for 45 minutes before the he was pronounced deceased.

SCDSS contacted law enforcement upon receiving the SCR report. SCDSS and law enforcement attempted to interview the subject mother and subject father in person; however, their whereabouts could not be determined. SCDSS was able to briefly speak with the subject father over the phone regarding the circumstances leading up to the subject child's death. During the investigation, the parents retained an attorney and declined to participate in any further interviews with law enforcement or SCDSS.

The medical examiner was notified and performed an autopsy on the subject child. The preliminary results indicated that the cause of death was undetermined, and the final autopsy report was not made available at the conclusion of the CPS investigation. Law enforcement had not made any arrests, and their investigation remained open, pending the final autopsy report.

The allegations of Inadequate Guardianship, Lack of Medical Care, and DOA/Fatality were substantiated against the subject mother and subject father regarding the subject child's death. Services in response to the subject child's death were offered but declined by the parents, and the investigation was subsequently closed.

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

Explain:
SCDSS made an appropriate decision to substantiate the allegations of Inadequate Guardianship and Lack of Medical Care based on information obtained throughout their investigation. The record does not support substantiating the DOA/Fatality allegation without knowing the cause of death. The autopsy report was not available at the time of the closing.

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:
There was detailed documentation of supervisory consult and case planning throughout the investigation.

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: 12/26/2024 **Time of Death:** 12:08 PM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: Steuben

Was 911 or local emergency number called? No

Did EMS respond to the scene? No

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	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)

LDSS Response

On 12/26/2024, SCDSS received a report regarding the death of the subject child. SCDSS initiated their investigation within 24 hours and coordinated efforts with law enforcement. SCDSS contacted the source of the report, completed a CPS history check, and informed the DA of the fatality. SCDSS made phone contact with the subject mother and subject father in an attempt to obtain their address for where they were residing prior to the subject child's death. However, the subject parents were unwilling to provide SCDSS with their locating information.

SCDSS was able to briefly speak with the father over the phone regarding the events leading up to subject child's death. The subject father stated that the subject child had two feedings during the night of 12/25/24. During the second feeding, the child "did not feed well" and they rushed him to the hospital. No further details were provided by the subject father. Throughout the investigation, the parents retained an attorney and were not permitted by their attorney to participate in interviews with SCDSS or law enforcement.

Collateral contact was made with the Emergency Department physician, who stated that the subject child arrived at the hospital accompanied by both the parents and the subject child had been unresponsive upon arrival. According to the physician, the mother reported that the subject child was unresponsive prior to making the hour trip to the hospital, and they did not have an explanation for the subject child's condition.

Medical records were received from the hospital which indicated that the subject mother reported that the subject child had been in a normal state of health until the morning of 12/26/24. At approximately 5:30AM, the father attempted to feed the subject child, but he appeared sleepy and refused to eat. They placed him back in the Pack 'N Play. At 9:00AM, the parents described the subject child as tired, with his eyes partially open, and he was not moving or making any sounds. The father swaddled the subject child and placed him back into the Pack 'N Play. By 10:00AM, the subject child was unresponsive and cool to the touch, prompting the parents to drive him to the hospital, which was approximately an hour away. The subject child remained unresponsive upon arrival at the emergency room. Despite life-saving measures, the subject child was pronounced deceased at 12:08PM.

SCDSS made collateral contacts with the maternal grandmother, maternal grandfather, and paternal grandfather. All

individuals stated they had never met the subject child and did not know where the family was residing.

SCDSS spoke with law enforcement, who indicated that their investigation was still open, awaiting the results of the autopsy. At the conclusion of the CPS investigation, the medical examiner reported that the toxicology reports were pending.

Services were offered to the family, but they declined. At the conclusion of the investigation, SCDSS substantiated the allegations of Inadequate Guardianship, Lack of Medical Care, and DOA/Fatality against both the subject mother and subject father. The Conclusion Narrative stated that although the medical examiner was unable to determine the cause of death, the parents did not act as reasonable parents would by obtaining immediate and nearby medical care. Furthermore, the inactions of the parents' contributed to the child's death. The record does not support substantiating the DOA/Fatality allegation without knowing the cause of death, which was not made available at the close of the CPS investigation.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending

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
069744 - Deceased Child, Male, 1 Month(s)	069745 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
069744 - Deceased Child, Male, 1 Month(s)	069745 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
069744 - Deceased Child, Male, 1 Month(s)	069746 - Father, Male, 31 Year(s)	DOA / Fatality	Substantiated
069744 - Deceased Child, Male, 1 Month(s)	069746 - Father, Male, 31 Year(s)	Inadequate Guardianship	Substantiated
069744 - Deceased Child, Male, 1 Month(s)	069745 - Mother, Female, 27 Year(s)	Lack of Medical Care	Substantiated
069744 - Deceased Child, Male, 1 Month(s)	069746 - Father, Male, 31 Year(s)	Lack of Medical Care	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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/20/2024	Deceased Child, Male, 11 Days	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 11 Days	Mother, Female, 27 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 11 Days	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 11 Days	Father, Male, 30 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SCR report stated that the SM gave birth to the child on 11/9/2024. The child was born full term but needed to be in the NICU due to having difficulties transitioning to life and a low body temperature. During the child's NICU stay, the father refused lab testing to be done on the child. On 11/20/24, the parents did not bring the child to his medical appointment for treatment and lab work that needed to be done. As a result, the child was at risk of infection.

Report Determination: Unfounded | **Date of Determination:** 11/27/2024

Basis for Determination:
SCDSS made contact with the SM and SF who agreed to bring the SC to the hospital; however, SCDSS lost sight of the family on the way to the hospital. The SF sent SCDSS emails showing that the SC was seen at the ER on 11/22/24 and at his pediatrician on 11/26/24. The family did not make themselves available to SCDSS stating that they were traveling for the holidays.

OCFS Review Results:
While the investigation met regulatory requirements, the family was very difficult to track down. SCDSS made one successful face-to-face with the parents and child. It was documented that SCDSS received confirmation that the child was seen at the ER and pediatricians' office; however, due to the parents' refusal to sign releases the record did not reflect the outcome of those appointments.

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

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 is no known CPS history outside of NY 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