Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-24-043

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

Issue Date: Mar 25, 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: Oneida
Gender: Male
Date of Death: 10/26/2024
Initial Date OCFS Notified: 10/26/2024

Presenting Information

On 10/25/24, at an unknown time, the mother put the 6-month-old subject child in his crib. At approximately 5:00AM the following morning, the mother went to check on the subject child and found him unresponsive and cold. The mother called 911, and the subject child was brought to the hospital. Life-saving measures were attempted; however, the subject child was pronounced deceased at 5:45AM. The subject child was otherwise healthy, and the mother had no explanation for his death.

Executive Summary

This fatality report concerns the death of the 6-month-old male subject child that occurred on 10/26/24. The Oneida County Department of Social Services (OCDSS) received a report from the SCR on the same day with allegations of DOA/Fatality and Inadequate Guardianship against the mother, with whom the subject child resided with at his time of death. Due to an active Order of Protection, the father did not reside in the home.

On the night of 10/25/24, the mother fed the subject child a bottle around 10:30PM and placed him in the adult bed to sleep. The mother stated the subject child regularly slept in an adult-sized bed, as when he was in the Pack 'N Play he wailed and disturbed the neighbors. The subject child fell asleep around 12:00AM, and the mother fell asleep around 12:30AM. At approximately 5:00AM, the mother got up to use the bathroom and checked on the child, who she found unresponsive. The mother started CPR and contacted 911. The subject child was transported to the hospital by EMS and pronounced deceased at 5:45AM.

OCDSS contacted the medical examiner who stated the subject child tested positive for Pertussis, and that there were no signs of trauma in the preliminary exam. The final autopsy report stated the cause of death was sudden unexpected infant death, and the manner of death was undetermined. It was noted the possibility of asphyxiation secondary to an inappropriate bedding situation (co-sleeping) could not be excluded.

OCDSS made multiple home visits to meet with the family. There were no surviving siblings in the home. The mother and father declined bereavement referrals offered by OCDSS, and the family denied the need for any additional assistance.

As of this writing, the CPS investigation remained open despite documentation present in the case record that demonstrated adequate information was obtained to make a determination.

PIP Requirement

OCDSS will submit a PIP to the Syracuse Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS will review the plan and revise as needed to address ongoing concerns.

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?** N/A

Explain:
The case record contained documentation that demonstrated adequate information was obtained to make a determination.

Was the decision to close the case appropriate? Unknown

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:
As of this writing, the CPS investigation remained open for OCDSS to obtain the incident report from the fatal incident; however, the case record demonstrated adequate information had been obtained to make a determination.

Required Actions Related to the Fatality

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

Issue:	Timeliness of Determination
Summary:	Despite having the information needed to make a determination, the investigation remained open as of this writing. There were no SSs in the home, and the SM and BF declined the need for any services.
Legal Reference:	SSL 424(7);18 NYCRR 432.2(b)(3)(iv)
Action:	The child protective service has the sole responsibility for making a determination within 60 days after receiving the report as to whether there is some credible evidence of child abuse and/or maltreatment so as either to "indicate" or "unfound" a report of child abuse and/or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/26/2024 **Time of Death:** 05:45 AM

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

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

Upon receipt of the report, OCDSS attempted to contact the source, completed a CPS history check on the family, collaborated efforts with LE, contacted the ME and the DA, and attempted a home visit. There were no surviving siblings in the home.

On 10/31/24, OCDSS met with the SM for a face-to-face interview. The SM stated the day of the incident was a normal day, and the SC showed no signs of illness. The SM stated she had been educated on safe sleep; however, the SC slept in the adult bed with her because he would wail when he was in the Pack 'N Play. The SM stated the SC would cry so loud the neighbors would complain about the SC crying; one of the neighbors was the landlord. The SM stated she would place the SC on the king size bed on his back, with a blanket up to his waist/chest leaving his arms out. The SM stated the SC was not crawling but started rolling over when he was on his stomach. The SM stated she gave the SC a bottle around 10:00-10:30PM, then she ate dinner while the SC was happily playing. The SM stated she and the SC went to bed around 11:30PM, and the SC fell asleep shortly after while the SM was on her phone. The SM fell asleep around 12:30AM. The SM stated she woke up around 5:00AM to use the bathroom and found the SC in the same position he had been put down in. The SM believed something was wrong with the SC and touched him. The SM stated the SC was cold, and when she

picked him up fluid came out of his mouth. The SM started CPR and called 911. EMS responded to the home and attempted to revive the SC. The SM stated the BF was not present the night of the incident and has not been around the SC due to the OP.

The BF was interviewed and stated the SC had a Pack 'N Play to sleep in, but he hated it. The BF did not have any additional information to provide as he had no contact with the SM and the SC due to an active OP. The BF denied having any concerns regarding the SM's care of the SC. During the investigation the OP was reduced to a refrain from, and the caregivers reunited.

OCDSS contacted relevant collaterals, including the ME, the SC's pediatrician, the hospital, a family friend, and obtained information from EMS. A neighbor also provided information to OCDSS on initial attempted contact, where concerns of ongoing domestic violence were shared.

As of this writing, the CPS investigation remained open for OCDSS to obtain the incident report related to the fatal incident despite the case record demonstrating adequate information was obtained to make a determination.

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: 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
070089 - Deceased Child, Male, 6 Month(s)	070090 - Mother, Female, 24 Year(s)	DOA / Fatality	Pending
070089 - Deceased Child, Male, 6 Month(s)	070090 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐

Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☐	☒	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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:

There was no documentation in the case record that family members were contacted as a collateral.

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.

Have any Orders of Protection been issued? No

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:
Bereavement referrals were offered to the caregivers. The SM completed paperwork with the funeral director to obtain burial assistance, therefore it was not offered by OCDSS.

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? N/A
Explain:
There were no surviving siblings or other children in the household.

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:
Referrals were offered to the SM and BF in response to the fatality.

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? Yes

Infants Under One Year Old

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)
04/25/2024	Deceased Child, Male, 1 Days	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 1 Days	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SM gave birth to the male subject child via emergency c-section. The SM tested positive for fentanyl and marijuana.

Report Determination: Unfounded

Date of Determination: 09/10/2024

Basis for Determination:
There was not a fair preponderance of evidence to substantiate the allegations of IG and PD/AM. The SM received an epidural which contained fentanyl during the birth of the SC which resulted in the SC's positive toxicology. The SM disclosed marijuana use.

OCFS Review Results:
OCDSS obtained adequate safety information during the first home visit; however, despite having been informed the SC had feeding issues which resulted in an extended hospital stay, and documented directives given on 5/28/24 to follow up with the pediatrician and see the SC, there was no documentation present in the case record of attempted contact until 8/12/24. The case record showed there was no contact with the caregivers, by phone or any other manner, from April to August. When the family was re-engaged, additional safety concerns regarding an incident of domestic violence were shared; however, no additional allegations were added.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
10 out of 32 progress notes were entered more than 30 days past their corresponding event date.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
Timely/Adequate Seven Day Assessment

Summary:

The 7-Day Safety Assessment was completed 26 days late.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

OCDSS will document and approve all safety assessments within the required timeframes.

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

OCDSS had no contact with the family from 5/28/24-8/17/24, and there was no casework activity documented in the case record from 5/28/24-8/12/24, despite the need for continued assessment of the subject child as he was noted to have medical concerns.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

OCDSS will continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3).

Issue:

Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:

OCDSS obtained new concerns regarding DV that occurred in the presence of the SC; however, there were no allegations added/substantiated against the BF despite the case record demonstrating a domestic incident report and the OP was obtained regarding the incident.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(c)

Action:

OCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained int eh original SCR report or discovered during the investigation.

Issue:

Timeliness of Determination

Summary:

The child protective service has the sole responsibility for making a determination within 60 days after receiving the report as to whether there is a fair preponderance of evidence of child abuse and/or maltreatment so as either to "indicate" or "unfound" within 60 days after receiving the report. This investigation was open for 144 days.

Legal Reference:

SSL 424(7);18 NYCRR 432.2(b)(3)(iv)

Action:

OCDSS will make a determination of either "indicated" or "unfounded" within 60 days after receiving the report.

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.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: The case record stated the SM obtained an OP against the BF following an incident of domestic violence in which LE responded. There were no details regarding the OP present in the case record.	

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