Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-24-048

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

Issue Date: Apr 01, 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: 8 month(s)
Jurisdiction: Herkimer
Gender: Male
Date of Death: 11/16/2024
Initial Date OCFS Notified: 11/16/2024

Presenting Information

An SCR report was received on 11/16/24 which alleged the subject child became unresponsive and cold to the touch while in the care of the mother and father. The father called 911 and emergency medical services (EMS) arrived a short time later. When EMS arrived, the parents and child were outside. EMS performed cardiopulmonary resuscitation (CPR) on the child and administered life-saving medications. The child regained a pulse enroute to the hospital, where he arrived via ambulance at 5:35PM. At the hospital, the child presented with fixed, dilated, and unresponsive pupils and threw-up yellow vomit. The child regained a normal body temperature but became unresponsive again at an unknown time and was pronounced deceased. The child was an otherwise healthy child, and the parents did not have an explanation for his death.

Executive Summary

This report concerns the death of the 8-month-old male subject child. Herkimer County Department of Social Services (HCDSS) received an SCR report regarding the child's death on 11/16/24. At the time of the child's death, he resided with his mother. The mother was residing in the home of her ex-paramour's mother (hereinto referred to as the family friend), along with that friend's adult child, that adult child's paramour, and an adult son-in-law. All members of the home except for the mother were unrelated to the child. The father was present at the home at the time of the incident; however, resided separately.

The day prior to the fatal incident, 11/15/24, the child was, "laughing, smiling, jumping, rolling, eating, and acting normal." The child had a slight cough that day and spent the night in the family friend's bedroom. He woke up around 2:00AM the morning of 11/16/24, crying. The child would not take his bottle but took the pacifier. The family friend woke again later in the morning at which time the child was still sleeping. She found that odd, but the child had only napped 30 minutes the day prior, so thought that may explain it. The friend left the home, and the mother and other adults continued to check on the child periodically. Around 1:55PM, the mother noticed the child "didn't look himself." He was sweating in his sleep but had no fever. Around 4:30PM, the mother noticed his hands were "ice cold." The mother spoke with the family friend about taking the child to the emergency room, though it was unknown what was advised or why the mother did not seek medical attention at that time. Reportedly around 5:15PM (though likely sometime before based on the 5:10PM 911 call time) another adult in the home contacted the family friend via a messenger app stating the mother attempted to wake the child but he was not breathing. The family friend, who was reportedly a nurse, called 911 on behalf of the family and walked them through rescue breaths until EMS arrived. EMS transported the child to hospital. On arrival, the child had a faint pulse but coded multiple times. The child was pronounced deceased at 6:29PM.

The medical examiner was notified and performed an autopsy on the child. The cause of death was "small bowel ischemia, NOS" and the manner of death was "natural." The autopsy report explained in that condition, a part of the intestine folds into itself, blocking the flow of nutrients. When the condition persists, the lack of oxygen to the bowel results in necrosis. Law enforcement investigated and there were no charges brought in relation to the death.

HCDSS made several home visits and interviewed the parents and other relevant household members.

HCDSS indicated the report and substantiated the allegation of Inadequate Guardianship against both parents. HCDSS

assessed the child was placed at imminent risk of harm when the parents failed to respond to his apparent illness by not seeking medical attention expeditiously and there was a delay in seeking medical assistance by contacting 911 via a person who was not present at the time of the incident and doing so over social media. The determination could have been better supported by eliciting additional information from medical staff. While early diagnosis and treatment was likely essential for the best possible outcome, medical staff were not asked about the signs and symptoms of small bowel ischemia. It was unknown if the symptoms the child displayed throughout the day (not eating, lethargy) were signs of acute distress due to small bowel ischemia and if a medical response earlier in the day would have resulted in a different outcome. It was unknown how much of a delay in calling 911 occurred due to calling the family friend first as that call time was not explicitly gathered (it was said to be about 5:15PM; however, EMS received a call at 5:10PM). DOA/Fatality was unsubstantiated.

Local mental health resources were provided to the family.

PIP Requirement

HCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) HCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, HCDSS 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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Was the decision to close the case appropriate?	Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:

While the parents' lack of response to the child's presentation on the day of the fatality was concerning, it was unknown if a swifter response would have produced a different outcome given the child presented normal the day prior. Additional information would have better supported the indication. It was unknown if the father was alerted to the worsening symptoms throughout the day.

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:	Information should have been sought from medical staff regarding the onset, duration, and known symptoms of the child's diagnosis to better determine if the parents placed the child in imminent danger by not responding more quickly.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	HCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/16/2024 **Time of Death:** 06:29 PM

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

County where fatality incident occurred: Herkimer
Was 911 or local emergency number called? Yes
Time of Call: 05:10 PM
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	8 Month(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Other Adult - Family Friend's adult child	No Role	Female	21 Year(s)
Deceased Child's Household	Other Adult - Paramour to 21yo Other Adult	No Role	Male	23 Year(s)
Deceased Child's Household	Other Adult - Family Friend (mother's ex-paramour's mother)	No Role	Female	46 Year(s)
Deceased Child's Household	Other Adult - Family Friend's son-in-law	No Role	Male	27 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	24 Year(s)

LDSS Response

On 11/16/24, HCDSS received a report regarding the death of the subject child. HCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. HCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. There were no surviving siblings or children in the household and a home visit was completed on 11/18/24, as law enforcement requested HCDSS wait on interviews.

HCDSS interviewed all adults regarding the events leading up to the child's death. On 11/15/24, the child had a little cough and fell asleep in the family friend's bed around 9:30-10:00PM. The family friend moved the child to a Pack 'n Play in her room. The Pack 'n Play did have a blanket placed underneath the child which was never observed to cover the child at any point. At 2:00AM, on 11/16/24, the child woke up screaming and crying. He would not eat but took his pacifier. The mother came into the friend's room to see what was wrong, and left after they calmed the child, and he went back to sleep. The friend woke up again around 5-6:00AM to change the child's diaper. He cried a little then went back to sleep. At 8:00AM, she checked on him again and he was still sleeping. While she thought it was strange as the child typically woke at 6:00AM, she thought he was extra tired due to not sleeping the day prior. She checked on the child again at 10:30AM prior to leaving the home for the day. Around 11:00AM, the mother woke the child and brought him downstairs. The child did not present as his normal energetic self and the mother and child spent the day on the couch because the mother thought the child did not feel well. She held him and tried to feed him a bottle, but he did not drink much. While holding the child, the mother noticed him turning blue and not breathing. Another adult in the home (the family friend's adult son) called the family friend via a messenger app. The family friend called 911 for the family and advised them to begin CPR. They carried the child to the kitchen and did CPR until EMS arrived. While the father was present that day, he was outside much of the day. He checked on the child at 9:30AM, at which time he appeared OK. He was alerted to the child's distress by the family friend's son and came inside to see the mother and other adults attempting CPR on the kitchen floor. Multiple times it was expressed the child appeared his normal self the day prior, but it was repeatedly expressed it was abnormal for him to be so lethargic.

An autopsy was completed and revealed no trauma or evidence of injury. There was no evidence of disease or injury other than an ischemic section of the small intestine. The autopsy report reflected the child developed normally and had regular pediatric visits. HCDSS obtained pediatric records which confirmed that as well. The autopsy report did not note a delay in medical care attributing to the child's condition and stated the cause of the small bowel ischemia was unknown; "however, intussusception of the bowel is most likely."

HCDSS contacted relevant collateral sources. Local mental health resources were provided to the family. Although not

required as there were no children residing in the home at the time of case closing, the Risk Assessment Profile was completed and inaccurate in that the elevated risk factor of death of a child because of abuse or maltreatment by caretakers was scored 'yes' despite the allegation of DOA/Fatality being unsubstantiated. It was learned the mother was pregnant and safe sleep recommendations were reviewed prior to closing.

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?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070294 - Deceased Child, Male, 8 Month(s)	070295 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
070294 - Deceased Child, Male, 8 Month(s)	070295 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
070294 - Deceased Child, Male, 8 Month(s)	070296 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
070294 - Deceased Child, Male, 8 Month(s)	070296 - Father, Male, 24 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?	☐	☒	☐	☐

Additional information:

The 30-Day Fatality Report was completed four days late.

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	☐	☐	☐	☐	☐	☒

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:
The family was provided a list of local mental health providers.

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)
03/11/2024	Deceased Child, Male, 23 Days	Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 23 Days	Mother, Female, 20 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 23 Days	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Deceased Child, Male, 23 Days	Other Adult - Mother's Paramour, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 23 Days	Other Adult - Mother's Paramour, Male, 22 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 23 Days	Other Adult - Mother's Paramour, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 23 Days	Other Adult - Family Friend (Paramour's Mother), Female, 46 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 23 Days	Other Adult - Family Friend (Paramour's Mother), Female, 46 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report received on 3/11/24 alleged that the subject child was living in poor home conditions that posed a safety hazard. There was water leaking from the ceilings and walls near exposed electrical outlets. There was no power in the kitchen due to water damage. There were six dogs in the home and dog urine on the floors. One of the dogs was aggressive. The mother and paramour smoked marijuana in the direct presence of the child. The grandmother (actually the paramour's mother, not the child's grandmother) owned the residence and was aware of the poor conditions but did nothing to improve the situation.

Report Determination: Unfounded | **Date of Determination:** 04/08/2024

Basis for Determination:
The child was assessed to be free of marks, bruises, lacerations, and observed in clean clothing. The home was assessed to meet minimum standards, and HCDSS assessed no safety concerns within the home. No exposed wires were observed. There were three nonthreatening dogs in the home. The home had no garbage or animal urine/feces and did not have an odor. No adults appeared to be under the influence of substances. The mother and paramour admitted to marijuana use but outside and away from the child. Medical collaterals confirmed the child was up to date medically.

OCFS Review Results:
The source was anonymous and unable to provide information regarding the allegations. A home visit was completed the day the report was received. The paramour's mother who owned the home reported repairs to the home would continue upon receipt of tax return money. No timeline for said repairs was discussed and as there was only one home visit, it was unknown if progress was made prior to case closure. The record reflected law enforcement records were received, though the record contained no details of the reports. The child's father resided elsewhere and did not respond to contact. He was included in the RAP, but it was unknown how questions were answered as no contact was made.

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

Issue:

Review of CPS History

Summary:

A CPS history check was completed untimely. The SCR report was received on 3/11/24. A 3/14/24 note reflected no indicated history, though for who was not documented. History was not fully documented until 4/11/24, the day the case closed.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within 1 business day of a report, HCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, HCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

[redacted]

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? 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