Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-24-051

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 8 month(s)
Jurisdiction: Jefferson
Gender: Female
Date of Death: 12/13/2024
Initial Date OCFS Notified: 12/13/2024

Presenting Information

An SCR report was received, which alleged on 12/12/24 at 7:00PM, the mother and father put the 8-month-old to sleep in her crib. The next day at 11:00AM, the parents went to feed the child and found her unresponsive in the crib. The parents contacted 911, it was unknown what actions the parents took during the time. The child was transported to the hospital and was pronounced deceased on arrival. The child was an otherwise healthy child, and the parents did not have an explanation for the child's death. A subsequent report was received on the same date with similar allegations.

Executive Summary

This report concerns the death of 8-month-old female child. Jefferson County Department of Social Services (JCDSS) received an SCR report regarding the child’s death on 12/13/24. At the time of the child’s death, she resided at home with her mother and father. There were no surviving siblings.

Through a joint investigation with law enforcement, it was learned the subject child was found unresponsive in her crib by the subject father. The subject father attempted Cardiopulmonary Resuscitation and contacted 911. The subject child was transported to the hospital via ambulance and life-saving measures were continued. The subject child was pronounced deceased at 11:55AM.

Medical records were received for the subject child. It was noted that the subject child was born at 30 weeks' gestation and spent time in the Neonatal Intensive Care Unit. The subject child was discharged from the hospital on 5/8/24, approximately two months after her birth. The subject child was following up with her primary pediatrician and ophthalmology as required.

The medical examiner was notified and performed an autopsy on the subject child. The cause of death was listed as Unexplained Death in Infancy with Intrinsic and Extrinsic Factors identified. The manner of death was listed as undetermined with multiple risk factors such as unexpected death in infant, potentially harmful bedding in the crib, prematurity/low birth weight, small gestational age, esophageal reflux and recent cough and diarrhea. Law enforcement closed their investigation with no charges against the mother or father.

JCDSS made the appropriate determination to substantiate the allegations of Inadequate Guardianship and DOA/Fatality against the mother and father and Parent's Drug Alcohol Misuse against the father regarding the death of the child. JCDSS stated that the parent's failure to exercise a minimum degree of care and the aggravating factors including the condition of the sleeping area was unsafe. The father admitted to using marijuana while being the sole caretaker of the child.

Services were offered in relation to the death and declined by the family. The CPS investigation was 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Safety Assessments were not required as there were no surviving siblings.

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: 12/13/2024 **Time of Death:** 11:55 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: 10:47 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	Female	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	18 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

On 12/13/24, JCDSS received a report regarding the death of the SC. JCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. JCDSS contacted the sources of the reports, completed a CPS history check regarding the family, and informed the DA of the fatality. JCDSS conducted an initial home visit on 12/13/24.

JCDSS interviewed the parents regarding the events leading up to SC's death. A timeline of the incident was provided by the father to JCDSS and law enforcement. It was learned that the mother left for work around 5:15AM, and the father checked on the child at that time. The father swaddled the child and placed her on a Boppy pillow in her crib. The father believed it to be around 10:40AM when he went back into the child's room to check on her. At that time, the father described the child as having a blue face, stiff and cold to touch. The father contacted his mother and went downstairs to call out for his mother's boyfriend. The father stated 911 was contacted while he started CPR. The father admitted that he had smoked marijuana out of a bong around 5:00AM; however, he denied being impaired.

The mother was interviewed by law enforcement and confirmed that she left for work at 5:15AM on 12/13/24. According to the mother, the child was sleeping through the night and typically woke up around 7:30AM. The morning of the fatal incident, the mother stated that she was receiving "snaps" from the father throughout the morning. Around 10:30AM, while at work, she was told by the paternal grandmother that she needed to leave work but was not told what had happened to the child.

A home visit was conducted at the residence of the subject child on 12/13/24. The home did not pose a safety risk, and the subject child's crib was observed with a fitted sheet and a Boppy pillow. JCDSS did not document if any drug paraphernalia was observed in the residence other than a "big torch" that was located in the parents' bedroom.

JCDSS contacted numerous collateral sources, including the paternal grandmother, the paternal grandmother's paramour, the paternal great-grandmother, the maternal grandmother, the pediatrician, hospital staff, and emergency medical personnel. None of these individuals had any concerns for the care that the child was receiving from the parents. The child's pediatrician was contacted and stated that the child was last seen on 10/8/24 for her 6 month well child checkup, and there were no noted concerns.

Services were offered to the family and were declined. At the close of the investigation, no criminal charges were brought against either parent. JCDSS found evidence to support the allegations in the report and substantiated the investigation. The investigation conclusion narrative stated that the parents failed to exercise a minimum degree of care. The aggravating factors in this circumstance included the physical condition of the sleeping area was unsafe. In addition, the father admitted to using marijuana while being the sole caretaker of the subject child which contributed to the father's ability to provide appropriate care for the child.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: Undetermined if injury or 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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069569 - Deceased Child, Female, 8 Month(s)	069571 - Father, Male, 18 Year(s)	DOA / Fatality	Substantiated
069569 - Deceased Child, Female, 8 Month(s)	069571 - Father, Male, 18 Year(s)	Inadequate Guardianship	Substantiated
069569 - Deceased Child, Female, 8 Month(s)	069571 - Father, Male, 18 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
069569 - Deceased Child, Female, 8 Month(s)	069570 - Mother, Female, 19 Year(s)	DOA / Fatality	Substantiated
069569 - Deceased Child, Female, 8 Month(s)	069570 - Mother, Female, 19 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?	☐	☒	☐	☐

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? 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
- ☐ 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 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