Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-21-034

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

Issue Date: Dec 31, 2021

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 has an open 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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 07/25/2021
Initial Date OCFS Notified: 07/25/2021

Presenting Information

An SCR report received on 7/25/21 alleged while being fed, the infant coughed then stopped breathing. A second SCR report received on the same day alleged the mother laid the 3-month-old infant down for a nap on a bed. The infant was lying on his back with four pillows around him and the mother was regularly checking on him. After approximately 45 minutes, the mother found the infant unresponsive. The mother called the father and 911 was called at approximately 4:20 PM. When EMS arrived, the infant was changing color and his heart was not beating. EMS performed CPR while transporting the infant to the hospital. The infant was put on a ventilator at the hospital and was given epinephrine. CPR was performed on him for approximately 45 minutes. Ultimately, the infant passed away at 5:27 PM. The paternal grandparents, aunt and uncle were present in the home when the infant was found unresponsive. There was no explanation for the infant's death.

Executive Summary

On 7/25/21, the Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report that alleged the 3-month-old male infant became unresponsive when he stopped breathing while being fed. A second SCR report was received on the same date, which alleged that the infant was found unresponsive and declared deceased after being placed on a twin sized bed for a nap. At the time of the infant’s death, he resided with his parents, paternal grandparents, two adult paternal aunts, an adult paternal uncle, a 16-year-old paternal aunt, a 7-year-old paternal uncle and three cousins, ages 5 and 4 years and 11 months. The children were assessed to be safe in the care of their parents.

The investigation revealed that on 7/25/21 around 2:30 PM, the mother swaddled the infant with a heavy fleece blanket, and she placed him on his back on a twin sized bed for a nap. She placed blankets around the infant in a u-shape to create a barrier around him. The 16-year-old aunt was napping on another bed in the same bedroom. The grandparents, one of the adult aunts, the 7-year-old uncle and the three cousins were in the dining room and living room of the home. The father and uncle were working, and the second adult aunt was visiting family in another country. The mother was checking on the infant about every 15 minutes and when she last checked on the infant, she found him to be unresponsive. She screamed for help and the grandfather called 911 at 4:22 PM. EMS arrived and performed CPR and they transported the infant to the hospital via ambulance. Life-saving measures were unsuccessful, and the infant was pronounced deceased at 5:27 PM.

OCDCFS conducted a home visit following the incident on 7/25/21 and they noted it was a very hot, humid day. First responders reported that the home was extremely hot when they arrived, and the infant was sweating when they were administering CPR.

Law enforcement investigated the incident, and they found no criminality and closed their case. The medical examiner reported that a full autopsy was not performed due to the family’s religious objection. An external examination showed no signs of foul play and the infant was well cared for. There were no injuries observed and the x-ray and toxicology results were normal. The cause and manner of death were undetermined.

OCDCFS interviewed all household members, and they contacted relevant collaterals. OCDCFS assessed the safety of the children timely; however, the 24-hour Safety Assessment was documented and approved in Connections one day late. The 7-day and 30-day Safety Assessments were not documented and approved in Connections. Notice of Existence letters were mailed to the required adults 72 days late on 10/12/21. Services related to the fatality were offered and the family

declined. The family reported that they had a lot of familial support as well as religious supports.

Based on the unsafe sleep environment, the mother swaddling the infant in a heavy blanket, and the extreme heat in the home, OCDCFS substantiated the allegation of Inadequate Guardianship against the mother. They unsubstantiated the allegations of DOA/Fatality against the mother, father, aunt, grandfather and the 16-year-old aunt and Inadequate Guardianship against the father, aunt, grandfather and the 16-year-old aunt. The 16-year-old aunt was not an adult or a person legally responsible for the infant and the mother was the sole caretaker of the infant at the time of the incident. The infant's cause of death was undetermined and there was a lack of credible evidence gathered that the mother's actions caused the infant's death.

PIP Requirement
OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS 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:**
  - **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

Explain:
The case was appropriately indicated and closed.

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:
Casework contacts were completed timely and relevant collaterals were contacted. Notice of Existence Letters were not provided in a timely manner and not all required Safety Assessments were completed.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	Notice of Existence Letters were mailed to all subjects and other persons named in the report 72 days late on 10/12/21.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	OCDCFS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour Safety Assessment was documented and approved in Connections one day late on 7/27/21.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	A Safety Assessment will be documented and approved by a supervisor within 24 hours of a report if such report contains the allegation of DOA/Fatality, as required.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	A 7-day Safety Assessment was not documented and approved in Connections.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	OCDCFS will document and approve all Safety Assessments within the required timeframe.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	A 30-day Safety Assessment was not documented and approved in Connections.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	OCDCFS will document and approve all Safety Assessments within the required timeframe.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/25/2021 **Time of Death:** 05:27 PM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 04:22 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant

☐ Playing ☐ Eating ☐ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 15 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **N/A**

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	Aunt/Uncle	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	16 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	30 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	27 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	7 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	69 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	54 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	4 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	5 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	11 Month(s)

LDSS Response

OCDCFS began their investigation into the infant's death upon receipt of the two SCR reports on 7/25/21. Within the first 24 hours, they documented a CPS history check and spoke to the sources of the reports, hospital staff, law enforcement, the DA's office and the medical examiner. Throughout the investigation, OCDCFS conducted home visits, interviewed all household members and assessed the children's safety. School staff and first responders from the fire department and ambulance company were spoken to and hospital records, EMS records, the infant's birth records, the autopsy report and the 911 call were reviewed.

The parents reported that the infant was healthy. They said they were educated about safe sleep guidelines at the hospital when the infant was born. They stated that the children all napped in a bedroom downstairs that had three twin-sized beds in it. The infant napped in that bedroom during the day and at night the infant slept in the parents' king-sized bed with the mother and the father slept on the floor. There was a crib in the parents' bedroom that they did not utilize for the infant. OCDCFS provided the family with a portable crib for the 11-month-old cousin, they discussed safe sleep guidelines with

the family, and they advised against the utilization of heavy blankets for swaddling infants.

Through interviews with the family, it was learned that on 7/25/21, the father fed the infant a bottle at 12:00 PM and he left for work around 12:30 PM. Around 1:30 PM, the mother brought the infant downstairs where the other family members were located. Around 2:30 PM, she brought the infant into the downstairs bedroom and he drank some of his bottle, then he fell asleep. The mother swaddled the infant in a heavy fleece blanket, and she placed him on one of the beds on his back. She placed blankets around the infant in a u-shape and she denied that the blankets were touching the infant. At that time, the 16-year-old aunt was napping on one of the other beds. The mother cleaned and did laundry while the infant napped and she checked on him about every 15 minutes. When the mother last checked on the infant, she noticed his mouth was opened a little and when she picked him up, he was not moving. The mother screamed and the other family members came into the room and assisted the mother with performing CPR, and they called 911 and the father.

The 16-year-old aunt reported that she was napping on one of the beds when the mother placed the infant on a second bed in the same bedroom. She woke up when the mother placed the infant on the bed, and she continued to lie on the bed and rest. She denied seeing or hearing anything concerning and she was unaware the infant was unresponsive until the mother entered the bedroom and picked up the infant.

Law enforcement reported that when they arrived at the home, the infant was on the floor in the living room. The infant's lips were blue, and he was profusely sweating since the home was very hot. All the windows were closed and there was no fan or air conditioner on. After they arrived, the family turned on an air conditioner that was in the living room window. Medical records showed the infant was up to date with medical care. He was last seen on 7/2/21 and there were no concerns noted.

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
Comments: The case was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059136 - Deceased Child, Male, 3 Mons	059138 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059142 - Aunt/Uncle, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059142 - Aunt/Uncle, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059143 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated

059136 - Deceased Child, Male, 3 Mons	059143 - Father, Male, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059139 - Grandparent, Male, 69 Year(s)	DOA / Fatality	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059139 - Grandparent, Male, 69 Year(s)	Inadequate Guardianship	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059144 - Aunt/Uncle, Female, 16 Year(s)	DOA / Fatality	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059144 - Aunt/Uncle, Female, 16 Year(s)	Inadequate Guardianship	Unsubstantiated
059136 - Deceased Child, Male, 3 Mons	059138 - Mother, Female, 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?	☐	☒	☐	☐

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	☒	☐	☐	☐

Explain:
Risk was adequately assessed for the surviving children and bereavement services were offered but declined.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
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	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The family declined bereavement services on behalf of the surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family declined bereavement services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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 CPS history outside of New York 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