Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-18-018

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

Issue Date: Aug 29, 2018

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 16 day(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 04/29/2018
Initial Date OCFS Notified: 04/30/2018

Presenting Information

An SCR report was received on 4/29/18, stating the SC died while in the care of his parents. The SC was an otherwise healthy child and his death was considered suspicious. A subsequent CPS report was received on the same date regarding the fatality. The subsequent report further alleged the SC had linear marks on his body and the SM's explanation was inconsistent with the marks and considered suspicious. Present in the home at the time of the incident were the SM, SF, PA and PGM.

Executive Summary

This report concerns the death of the 16-day-old male SC. Oneida County Department of Social Services (OCDSS) received two SCR reports on 4/29/18 regarding the SC's death. The SC was a healthy child with no known medical concerns and his sudden death was considered suspicious. There were no SS or other children residing in the SC's home.

The SM and SF fed the SC in the early morning hours of 4/29/18, without any concerns. They then placed the SC to sleep in his bassinet. Between 4:30AM and 5:00AM the SM and SF checked on the SC and found him unresponsive. Emergency services were called and the SC was taken to the ER. The SC could not be revived.

The ME was notified and performed an autopsy. The preliminary autopsy showed no signs of trauma. A doll re-enactment was conducted and resulted in unremarkable findings. The ME expressed no concerns regarding the sleep position or sleep environment of the SC. The toxicology results were outstanding at the time of this writing and the cause and manner of death were pending the final autopsy report.

LE investigated the fatal incident and found no basis for criminal charges against the SM, SM, PGM or PA.
At the time this report was written OCDSS had not made a determination of the allegations. OCDSS continued to visit with the SM and SF and were awaiting the autopsy results.

OCDSS offered the SM and SF burial assistance and grief counseling.

OCDSS interviewed the SM, SF and PGM. OCDSS did not speak with the PA. There was case documentation that OCDSS attempted to contact the state officials where the PA lived to request they interview her, but there were no attempts to directly contact the PA. OCDSS did not document speaking with emergency medical personnel or the SC's pediatrician. OCDSS completed all the safety assessments and other reports in a timely manner.

PIP Requirement
OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? N/A

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:
The investigation remained open at the time of this writing.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Child Protective Services casework contacts
Summary:	The case record does not contain documentation that OCDSS attempted to contact the PA. The PA was a subject of the report and her phone number was provided to OCDSS by the PGM.
Legal Reference:	432.2(b)(4)(vi)
Action:	OCDSS will make efforts to make casework contacts with biological parents and/or other persons named in a report.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There is no documentation in the case record that OCDSS attempted to contact medical personnel that treated the SC or the SC's pediatrician. OCDSS did not contact the source of the subsequent fatality report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/29/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 04:30 AM

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 alcohol or drugs? No
Child's activity at time of incident:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- [ ] Drug Impaired
- [ ] Alcohol Impaired
- [ ] Distracted
- [ ] Impaired by disability
- [ ] Absent
- [x] Asleep
- [ ] Impaired by illness
- [ ] 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	16 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	62 Year(s)
Other Household 2	Aunt/Uncle	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

OCDSS began their investigation into the fatality on 4/29/18, after receiving an SCR report. OCDSS contacted the source, checked for CPS history, contacted LE and verified the DA was notified. OCDSS learned the SM and SF had no CPS history and there were no surviving children in the home. The SM had no other children. The SF had another child that was 21-years-old at the time of the SC's death. The 21-year-old did not live in the home.

OCDSS spoke with the SM and SF on 4/30/18, in their home. At that time, the PGM and PA were not present and did not live at the SC's residence. The SF explained that the PGM and PA were visiting at the time of the SC's death and have since returned to their homes. The PA lived out of state and the PGM in other county within New York State. The SM was unsteady on her feet and lethargic while interacting with OCDSS. The SM reported she was in a substance abuse program,

where she received counseling and medication regularly. She reported taking the medication throughout her pregnancy and after the birth of the SC. The SM signed releases for OCDSS to speak with the treatment provider and denied any illicit drug use. OCDSS observed a bassinet and other appropriate provisions for the SC. The SM and SF told OCDSS they have had safe sleep education and practice safe sleep. The SM and SF reported they were awake with the SC the night of 4/28/18 and early morning, of 4/29/18, and he was acting normally. At some point in the early morning the SC was given a bottle and then placed on his back in the bassinet with a baby blanket tucked around the lower part of his body. At around 5:00AM the SM and SF checked on the SC and found him unresponsive. The SC was in the same position they placed him in and the blanket had loosened, but was still in the same position. The parents called 911 for assistance, and when EMS responded they took the SC to the ER.

OCDSS spoke with the PGM when she was at the parents' home after the funeral services. The PGM said on 4/29/18 everyone was asleep and at around 4:30AM she woke to the SM screaming for someone to call 911. The PGM and SM both called 911. The PGM reported when EMS arrived they initially drove past the home and the SF took the SC outside for help before they could enter the home. The PGM stated the SM and SF took very good care of the SC and he had no medical problems.

OCDSS made numerous attempts to contact the state where the PA lived, to request she be interviewed. The attempts were unsuccessful. OCDSS received a telephone number for the PA from the PGM. There is no documentation in the case record that they attempted to call the PA directly.

LE told OCDSS that when they responded to the SC's home the morning of 4/29/18, the SM was nodding off and appeared under the influence of a substance. The SF was sober. LE interviewed the SM, SF, PGM and PA and there were no concerns regarding the care of the SC. LE observed a bassinet in the home and learned the SC was in the bassinet on his back when the incident occurred.

OCDSS spoke with the SM's substance abuse treatment provider multiple times throughout the investigation. SM's counselor reported the SM was actively engaged in treatment and attended groups and counseling several days a week. She also stated the SM was present at the program 6 days a week for her medication. The SM was regularly drug tested and was negative for all substances, other than her prescribed medication. The counselor stated the SM became compliant in March of 2018 and had been doing well since then. After the death of the SC, the SM also began grief counseling with the treatment program.

Official Manner and Cause of Death

Official Manner: Pending
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 reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

047351 - Deceased Child, Male, 16 Days	047354 - Grandparent, Female, 62 Year(s)	DOA / Fatality	Pending
047351 - Deceased Child, Male, 16 Days	047352 - Mother, Female, 27 Year(s)	DOA / Fatality	Pending
047351 - Deceased Child, Male, 16 Days	047353 - Father, Male, 42 Year(s)	Lacerations / Bruises / Welts	Pending
047351 - Deceased Child, Male, 16 Days	047353 - Father, Male, 42 Year(s)	DOA / Fatality	Pending
047351 - Deceased Child, Male, 16 Days	047355 - Aunt/Uncle, Female, 26 Year(s)	Lacerations / Bruises / Welts	Pending
047351 - Deceased Child, Male, 16 Days	047354 - Grandparent, Female, 62 Year(s)	Inadequate Guardianship	Pending
047351 - Deceased Child, Male, 16 Days	047354 - Grandparent, Female, 62 Year(s)	Lacerations / Bruises / Welts	Pending
047351 - Deceased Child, Male, 16 Days	047352 - Mother, Female, 27 Year(s)	Lacerations / Bruises / Welts	Pending
047351 - Deceased Child, Male, 16 Days	047352 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Pending
047351 - Deceased Child, Male, 16 Days	047353 - Father, Male, 42 Year(s)	Inadequate Guardianship	Pending
047351 - Deceased Child, Male, 16 Days	047355 - Aunt/Uncle, Female, 26 Year(s)	Inadequate Guardianship	Pending
047351 - Deceased Child, Male, 16 Days	047355 - Aunt/Uncle, Female, 26 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 PGM resided in another jurisdiction and was interviewed over the telephone. The PA lived in another state and several attempts were made to contact that state and request a courtesy visit to interview the PA.

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 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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief Counseling were provided and multiple services were already in place through the substance abuse program the SM attended.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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 is no history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known 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