Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-17-029

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

Issue Date: Dec 27, 2017

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: 4 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 07/08/2017
Initial Date OCFS Notified: 07/08/2017

Presenting Information

An SCR report was received on 7/8/17 and alleged at approximately 6:45AM, SM and SF found the 4-month-old SC in his crib not breathing. SF called 911 and EMS responded to the home. When EMS arrived, SF was holding the baby on the font sidewalk, and SM was there as well. It was unknown exactly what time SC died, but the parents last saw him alive the previous night around 11:30PM. SC's body did not have any visible injuries, nor did he have any preexisting medical conditions.

Executive Summary

This fatality report concerns the death of a 4-month-old male (SC) that occurred on 7/8/17. A report was made to the SCR on this same date, with allegations of IG and DOA/Fatality against SM and SF regarding SC. Onondaga County Department of Social Services (OCDSS) conducted a thorough investigation surrounding SC's death. Neither a Death Certificate nor final autopsy report were available for review at the time of this writing, therefore the cause and manner of death had not yet been determined.

SC was born one month premature and with a positive toxicology, but had no on-going medical issues as a result. SC was an otherwise healthy child, with no concerns noted by his pediatrician. SC had resided with SM and SF, and there were no surviving siblings or other children in the household. It was discovered on the night of 7/7/17, SM fed SC a bottle, and then placed him to sleep with SF and herself in their adult bed, as was their normal practice. SM and SF awoke around 6 or 7AM, and found SC on his back and unresponsive. Emergency services were called and transported SC to the hospital, where he was pronounced deceased. The investigation revealed SM and SF had been educated surrounding safe sleep practices numerous times by OCDSS caseworkers as well as community service providers. A Pack and Play was observed in the home, but was reportedly not being used.

From the time the investigation began to the time of this writing, OCDSS met with and interviewed SM, SF, and several other family members, followed up with numerous collateral contacts, assessed home environments, and referred family members to grief and trauma services. At the time of this writing, the fatality investigation remained open, and there were no criminal charges pending as a result of SC's death.

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?** 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 fatality investigation remained open at the time of this writing; however, the final Safety Assessments and determination were completed and pending approval. All were appropriate, and casework was commensurate with the case circumstances.

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/08/2017 **Time of Death:** Unknown

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: 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:

☒ 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? 5 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

On 7/8/17, OCDSS received a report regarding the death of SC. OCDSS initiated their investigation within 24 hours, and coordinated their efforts with LE. OCDSS contacted the source of the report, informed the District Attorney of the death, reviewed CPS history for SM and SF, and made initial contact with the parents. SM and SF were no longer residing at their apartment. OCDSS discovered they were staying with MGM at her home, and met with the family there.

OCDSS learned SC was an only child, and SM, SF, and SC resided together in their own home at the time of the death. After SC's passing, SM and SF planned on staying with MGM and her family until they found a new apartment. OCDSS appropriately observed and assessed the safety of the home and the children that resided in that household (MGM's 10-year-old son and 1-year-old granddaughter); no concerns were noted. All adults that lived in the home were also spoken with (MGM's boyfriend and MA). OCDSS promptly offered all family members grief and trauma services, which they initially accepted.

Through interviews, it was learned SM put SC down to sleep at approximately 11:30PM on 7/7/17. SM placed SC in SM and SF's queen sized bed, which was where SC would sleep nearly every night. SC did have a Pack and Play available to him, but it was rarely used, and later interviews revealed both parents were educated several times surrounding the dangers of an unsafe sleep environment. SM explained sometime between 11:30PM and 1AM, she fed SC a bottle of approximately four ounces of formula. She stated that was their usual routine, and then SC would fall back asleep until around 6AM or 7AM, when he would wake to eat again. SM explained when she and SF awoke at their usual time, they found SC unresponsive. SM stated she immediately began administering CPR, and then went to the neighbors to have them call 911, as both her and SF's phones were not charged. EMS arrived and transported SC to the hospital, where he was pronounced deceased.

SM and SF reported SC was a healthy child, and had no preexisting medical conditions. SC was born one month premature with positive toxicology, but had no on-going complications as a result. SC received his 4 month immunizations on 6/28/17, which caused a low-grade fever at first, but SC was otherwise acting normally since. SM, SF, and SC were involved with Healthy Families (HF), and OCDSS reached out to the case manager regarding the family. OCDSS was informed SM and SF were not engaging and HF had planned to close their case as a result. The HF case manager also expressed concerns that at their 4/28/17 visit, it appeared SC's diaper had not been changed the entire night, and she suspected SM and SF of possible drug use. There was no SCR report made, nor is it clear by the case record if the HF case manager made anyone aware of her concerns. Both SM and SF denied they were under the influence of drugs or alcohol at the time of SC's death.

LE had previously conducted a reenactment with SM and SF, and found SC was placed on his back when he went to sleep,

and was still on his back when found. It was also determined SC was at the foot of the parents' bed, and SM and SF were laying perpendicular around the mattress. OCDSS also completed a home visit to the case address where SC was found unresponsive. The home was found to be messy, but had clear pathways and met minimal standards.

Throughout the investigation, OCDSS contacted an array of collateral sources, including LE, the ME, EMS, and SC's pediatrician. At the time of this writing, the cause and manner of death were not yet determined; however, preliminary results showed no physical injury or trauma to SC. There were no criminal charges filed against the parents, and OCDSS's fatality investigation remained open.

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
Comments: This fatality investigation was conducted by the Onondaga Multi-Disciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality investigation was reviewed by the Onondaga County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042382 - Deceased Child, Male, 4 Mons	042383 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
042382 - Deceased Child, Male, 4 Mons	042383 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
042382 - Deceased Child, Male, 4 Mons	042384 - Father, Male, 22 Year(s)	DOA / Fatality	Substantiated
042382 - Deceased Child, Male, 4 Mons	042384 - Father, Male, 22 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?	☐	☒	☐	☐

First Responders	☐	☒	☐	☐
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:
OCDSS contacted appropriate collateral sources, with the exception of First Responders; the case record does not reflect First Responders were spoken with, or that any attempts were made.

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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no SS or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Grief and trauma services were offered to the family in response to SC's death, and referrals were made. SM and SF did not follow through with engaging in services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/15/2017	Deceased Child, Male, 1 Days	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Far-Closed	Yes
	Deceased Child, Male, 1 Days	Mother, Female, 21 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
This report was received with concerns SM was positive for marijuana upon giving birth to SC. Further information revealed the SC also tested positive for marijuana.

OCFS Review Results:
The investigation was tracked appropriately to FAR. OCDSS addressed initial concerns with the family, and completed all assessments on time and adequately. There was information revealed during the investigation that SC was also born positive for cocaine; however, OCDSS did not follow up with the hospital to confirm this information.

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

Issue:
FAR-Failure to Address Reported or Identified Concerns

Summary:
OCDSS learned SC may have also been positive for cocaine at the time of his birth, but did not follow-up with collateral contacts to confirm this.

Legal Reference:
18 NYCRR 432.13 (a)(3)(iii)

Action:
OCDSS will fully address all concerns as they arise during an investigation.

[redacted]

CPS - Investigative History More Than Three Years Prior to the Fatality

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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