Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-18-050

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

Issue Date: Apr 23, 2019

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		

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 11/20/2018
Initial Date OCFS Notified: 11/20/2018

Presenting Information

An SCR report was received which alleged on 11/20/18, the mother awoke with the subject child and his twin brother sleeping in the same bed as her. The mother realized the subject child was not breathing and called 911, but the child could not be revived. The cause of death was unknown and the twin brother was unharmed. The roles of the five surviving siblings were unknown.

Executive Summary

This fatality report concerns the death of a 3-month-old subject child (SC) that occurred on 11/20/18. A report was made to the SCR on the same date, with allegations of Inadequate Guardianship and DOA/Fatality against the subject child's mother (SM). The Onondaga County Department of Social Services (OCDSS) received the report and began an investigation into the child's death. An autopsy was completed and the cause of death was noted as "sudden death associated with unsafe sleep environment" and the manner listed as "undetermined."

At the time of the child's death, he resided with his mother, twin brother, and four other siblings (ages 2, 6, 7, and 10). It was discovered on the morning of 11/20/18, the mother had been co-sleeping with the twin infants in an adult bed; both children were placed on "Boppy Pillows." The mother awoke at 6:45AM to find the subject child laying on his back, unresponsive. The mother contacted EMS, and they responded to the home alongside law enforcement. The child was pronounced deceased at the scene, and the Medical Examiner transported the child for an autopsy.

From the time the investigation began to the time of closure, OCDSS met with the mother and interviewed all verbal surviving siblings. OCDSS addressed all concerns that arose in an appropriate and prompt manner. The home and the children were observed on more than one occasion with no safety concerns noted. OCDSS spoke with several collateral sources and offered the family a referral for bereavement counseling; no other services were offered. There were no criminal charges pursued against the mother. OCDSS gathered sufficient evidence to substantiate all allegations. The report was indicated and closed.

PIP Requirement
OCDSS will submit a Program Improvement Plan (PIP) to their Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed to further address on-going 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:
Sufficient information was gathered to appropriately determine the case; however, OCDSS did not complete a thorough interview with SM regarding the death of SC, and obtained most of their information surrounding the events of the fatality from the ME.

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 notes a consultation took place, but no details noted.

Explain:
The decision to indicate and close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Although OCDSS contacted the pediatrician, the notes reflected records were received for only 3 of the 6 CHN.
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.
Issue:	Failure to offer services
Summary:	The record reflected OCDSS offered the family a referral for bereavement counseling, but no other services. The mother may have benefited from family planning and/or domestic violence services.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	OCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.
Issue:	Failure to provide notice of report
Summary:	A Notice of Existence Letter was not mailed/delivered to the biological father of the SC and his twin until 1/7/18.

Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	OCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Although OCDSS met with SM and discussed with her concerns regarding supervision, discipline and sleep safety, OCDSS did not ask SM questions relating to the day of SC's death or the events leading up to it.
Legal Reference:	432.1 (o)
Action:	OCDSS will adequately facilitate information gathering and analysis of safety factors during face-to-face contacts with a child and/or a child's parents or guardians.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/20/2018 **Time of Death:** 06:45 AM (Approximate)

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? 4 Hours
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ 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	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Month(s)
Other Household 1	Father	No Role	Male	32 Year(s)
Other Household 2	Other Adult - BF of SS2, SS3, SS4	No Role	Male	33 Year(s)
Other Household 3	Other Adult - BF of SS5	No Role	Male	40 Year(s)

LDSS Response

On 11/20/18, OCDSS received the SCR report regarding the death of SC, which occurred on that same date. OCDSS initiated their investigation of the reported fatality within 24 hours and coordinated their efforts with their Multidisciplinary Team. OCDSS learned there were 5 surviving siblings, including the SC's twin brother, and promptly worked to assess their safety.

On the date the report was received, OCDSS observed the oldest sibling in the care of his father and noted no concerns. This child was not interviewed about the fatality at this time because he did not know yet his brother had passed away. OCDSS then met with the 2 female siblings and the 2yo sibling at their biological father's home. OCDSS interviewed the two female siblings and all they knew of the fatality was that their brother was not breathing the morning prior; however, they each expressed unrelated concerns surrounding general supervision and physical discipline at home. Due to the concerns, OCDSS worked with the family to implement a safety plan where the siblings would not stay in the care of their mother until OCDSS could investigate further. The plan was agreed to by all parties.

Also on 11/20/18, OCDSS spoke with the ME. The ME reported the 7 and 10yo siblings were caring for the twins, and at around 10:30PM, they brought the twins upstairs to their mother. The ME reported the mother informed her she then placed both twins in bed with her, and awoke around 1AM to feed them; SC would not eat. The twins were each placed on their sides in their own "Boppy Pillow" in the middle of the queen size bed. The mother reported to the ME she awoke around 6:45AM and found SC on his back, cold and "in rigor." The ME stated SC was not transported to the hospital via ambulance, and instead was brought to her office for autopsy.

On 11/21/18, OCDSS completed an interview with SM at a relative's home. OCDSS did not speak with SM regarding specifics of the fatality, or the events leading up to and proceeding such. OCDSS reviewed the unrelated supervision and discipline concerns with SM, all of which she denied. OCDSS also educated the mother surrounding safe sleep practices. The record did not reflect if the mother had been previously educated surrounding this. At the conclusion of this home visit, SM agreed to continue the safety plan through the weekend.

On 12/8/18, a subsequent SCR report was received by OCDSS with allegations surrounding SM failing to make a supervision plan for her CHN. The initial Safety Plan was implemented on 11/20/18; however, OCDSS had not followed up with any family members involved regarding that plan from the time of the initial report to the time of the subsequent. When the subsequent report was received, OCDSS learned the SS were back at home with SM. OCDSS gathered information surrounding the new allegations and again met with and observed the SS; no concerns were noted at that time, and OCDSS did not feel the Safety Plan needed to be re-implemented. On 12/10/18, the caseworker attempted to interview

the oldest sibling at his school regarding the fatality, but he reported he did not want to discuss it. On the same date, OCDSS completed a home visit to SM's residence. There were no safety concerns noted, and OCDSS observed appropriate sleeping provisions for the children.

Throughout the investigation, OCDSS assessed the safety of the SS and spoke with collateral sources. Bereavement counseling referrals were offered to the family. OCDSS gathered sufficient evidence to substantiate the allegations regarding the fatality, but did not find evidence to substantiate the allegations from the subsequent report. The case was indicated and closed.

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
Comments: This fatality investigation was conducted by the Onondaga County Multidisciplinary Team.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
049733 - Deceased Child, Male, 3 Mons	049741 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
049733 - Deceased Child, Male, 3 Mons	049741 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
049744 - Sibling, Female, 6 Year(s)	049741 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
049745 - Sibling, Female, 7 Year(s)	049741 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated

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:

Several collateral sources were contacted. SC was not brought to the ER, therefore no hospital staff needed to be spoken with. OCDSS did not make attempts to speak with the CHN's biological fathers face to face, but did speak with them via phone.

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:
OCDSS offered the family bereavement service referrals. SM may have benefited from family planning services and domestic violence services (regarding her recent relationship with the SS' BF); however, these services were not offered.

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?	☐	☒	☐	☐

Explain as necessary:
There were no children that needed to be removed as a result of this fatality investigation or for reasons unrelated.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Referrals for bereavement counseling were offered to the family. SM reported a recent history of interpersonal violence with some of her CHNs' biological father; however, DV services were not offered. SM also may have benefited from family planning services.

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? Yes
Explain:
OCDSS provided SM with a referral for bereavement counseling for herself and the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
A referral for bereavement counseling was provided to SM for the family.

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? 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
☒ 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

12/2014-UNF against SM for IG, XCP, and L/B/W regarding an unrelated child.

Known CPS History Outside of NYS

There is 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