Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-019

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

Issue Date: Sep 30, 2020

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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Oneida
Gender: Female
Date of Death: 09/02/2017
Initial Date OCFS Notified: 05/19/2020

Presenting Information

An SCR report was received which stated that on 9/2/17, the father was driving with the subject child and her sibling in his vehicle when he fell asleep at the wheel and crashed into a telephone pole. As a result, the subject child sustained multiple injuries including a skull fracture. The subject child died as a result of the injuries. The report alleged the father stayed up for numerous hours playing video games each night, and due to this, was unable to safely operate a vehicle.

Executive Summary

This fatality report concerns the death of a 4-year-old female subject child that occurred on 9/2/2017. A report was made to the SCR on 5/20/20 with allegations of Inadequate Guardianship and DOA/Fatality against the child's biological father. There were additional allegations regarding the surviving sibling and two surviving half-siblings unrelated to the fatality. Oneida County Department of Social Services (OCDSS) received the report and completed a thorough investigation into the child's death. An autopsy was performed, and the official cause of death was noted as blunt force trauma of the head due to a pickup truck/fixed object collision. The manner of death was noted as accidental.

At the time of the child's death, she resided with her mother and 1-year-old brother and had visitation with her father regularly. The half-siblings involved in this case had not yet been born at the time of the child's death. The investigation revealed that on 9/2/17, the father was driving with the child and sibling in his vehicle to meet up with family at a restaurant. At some point, the father fell asleep briefly behind the wheel, and the vehicle veered off the road, crashing into a telephone pole. The subject child sustained life-threatening injuries due to a direct impact to her head; however, the sibling had only minor injuries caused by car seat restraints. Emergency services were called and when they arrived at the scene, it was determined the child needed to be airlifted to the hospital. The child lost vitals in the helicopter, and she was pronounced dead at the hospital at 5:09PM.

From the time the investigation began to the time of this writing, family members were interviewed, and pertinent collateral sources were contacted. The safety of the sibling and half-sibling was assessed on more than one occasion with no concerns noted. OCDSS offered the family appropriate services in response to the fatality. There were no criminal charges brought against the father as he did not have a documented medical condition that prevented him from driving safely prior to the accident. The CPS investigation had not yet been determined at the time this report was issued, as OCDSS was awaiting to speak with a collateral source who was present at the scene of the accident. Therefore, the investigation remained open and ongoing.

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?** 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?** Unable to Determine

Explain:
Sufficient information was gathered to assess the safety of the SS and surviving half-siblings. The case had not yet been determined at the time of this writing.

Was the decision to close the case appropriate? Unknown
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 case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

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: 09/02/2017 **Time of Death:** 05:09 PM

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

County where fatality incident occurred: Madison
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
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	Female	4 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)

LDSS Response

On 5/19/20, OCDSS received the SCR report regarding the death of SC, which occurred on 9/2/17. OCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. It was determined family members resided in two separate counties in addition to Oneida County: SF lived in Madison County, and a surviving half-sibling resided with his biological mother in Onondaga County. In response, OCDSS assigned Madison County Department of Social Services (MCDSS) and Onondaga County Department of Social Services (Onondaga CDSS) secondary roles to assist in the investigation.

On 5/19/20, Onondaga CDSS met with SC's surviving half-sibling and his biological mother at their home. The half-sibling had not yet been born at the time of SC's death. The mother explained she was at work when the car accident occurred and received a call from SF after it happened. The mother said SF would stay up all night playing video games and ignore the needs of his CHN. At the time of this writing, SF had supervised visits with the half-sibling for 2 hours each week. Onondaga CDSS observed the half-sibling to be safe and the home environment to be appropriate.

On 5/19/20, OCDSS met with BM and SS. BM's boyfriend and their 6-month-old son were also present. BM explained SF had a history of falling asleep while driving and had done so several times since she had known him. She stated he had never gotten into an accident prior to the fatal accident in 2017. BM explained when she was in a relationship with SF, she would never allow him to drive anywhere; however, they had not been together for some time when the accident occurred. On the date of the accident, BM reported SF had taken the CHN to eat breakfast with his family in a nearby town. She explained around 2PM that day, she received a call from SF and learned what had happened. BM said SC died in the helicopter on the way to the hospital. She stated she never understood why SF was not charged criminally in the accident. BM said SF would play video games and ignore the CHN. She stated she and SF share joint custody of the SS, and SF would have SS Friday to Monday, every other week. There was also an order in place that SF could not drive with SS in

the car for longer than one hour. OCDSS attempted to speak with SS; however, he would not engage. SS was observed to be safe and the home environment was free from hazards. BM's boyfriend was interviewed, but he had no knowledge surrounding the fatal incident as he did not know BM at that time. The infant was assessed as safe and OCDSS provided the parents with safe sleep information.

Throughout the investigation, MCDSS completed several visits to SF's home. SF explained the accident on 9/2/17 occurred because he fell asleep at the wheel and he hit a telephone pole. He stated SC and SS were in the car with him at the time. SF reported there was an investigation into the accident, and he attended court hearings; however, he was not found criminally responsible. SF said he had fallen asleep behind the wheel twice since he became a licensed driver; however, it had never caused an accident until the fatal accident in 2017. SF stated after the incident, he completed medical testing and found he had medical conditions that were causing his drowsiness. He stated since he began treatments for such, there were no other instances of him falling asleep while driving. SF denied the allegations that he played video games all night and neglected the care of his CHN. SF stated he only played video games after the CHN were asleep and would stop if they awoke or needed anything. MCDSS observed appropriate provisions for the SS and the home was deemed safe.

OCDSS spoke with several collateral sources, including EMS, LE, hospital staff and relatives. LE found no criminality, and OCDSS offered the family appropriate services. The investigation remained open pending contact with a collateral source.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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 Oneida County MDT.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054964 - Deceased Child, Female, 4 Yrs	055002 - Father, Male, 27 Year(s)	Inadequate Guardianship	Pending
054964 - Deceased Child, Female, 4 Yrs	055002 - Father, Male, 27 Year(s)	DOA / Fatality	Pending
055004 - Sibling, Male, 1 Year(s)	055002 - Father, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Pending
055004 - Sibling, Male, 1 Year(s)	055002 - Father, Male, 27 Year(s)	Inadequate Guardianship	Pending
055004 - Sibling, Male, 1 Year(s)	055002 - Father, Male, 27 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐
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:

Interviews with the family and appropriate collateral sources were completed. Attempts were made to interview the SS, but he would not engage. Progress notes and other documentation were completed and entered timely.

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 appropriate services in response to the SC's death, but they were 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?	☐	☒	☐	☐
Explain as necessary: The SS did not need to be removed as a result of this fatality report.				

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:
Appropriate services were offered to the family in response to SC's death; however, the family declined.

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:
Although offered, the family declined the need for services as the death occurred several years ago.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Although offered, the family declined the need for services as the death occurred several years ago.

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? No
Was the child acutely ill during the two weeks before death? No

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 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 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