Child Fatality Report

Report Identification Number: SY-19-058

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

Issue Date: May 07, 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: 11 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 01/06/2003
Initial Date OCFS Notified: 12/04/2019

Presenting Information

An SCR report was received with concerns that approximately 10 years ago, the mother became upset with her 11-month-old child, took him out of his crib and shook him. The child was in distress as a result, but the mother did not seek medical attention until the following day. The child died at the hospital.

Executive Summary

This fatality report concerns the death of an 11-month-old male subject child that occurred on 1/6/03. A report was made to the SCR on 12/4/19 with allegations of Choking/Twisting/Shaking, Lack of Medical Care, Lacerations/Bruises/Welts and DOA/Fatality against the child's mother (SM). Onondaga County Department of Social Services (OCDSS) received the report and investigated the child's death. An autopsy was performed on 1/7/03, and the official report was obtained by OCDSS. The cause of death was listed as positional asphyxiation and the manner was undetermined. The medical examiner noted the child had a history of seizures and recent flu-like symptoms in the days leading up to his death. There were no significant injuries or bruising to the child's body found upon examination.

At the time of the child's death, he resided with his mother in a shelter for young parents. The child had no siblings at the time, and paternity had not been established. The investigation revealed on the night of 1/5/03, the mother and child spent the night at a friend's home. The child had fallen asleep in his stroller some time around 11:00 PM, and the mother went to sleep on a couch around 3:45 AM. At approximately 8:00 AM, the mother awoke and brought the child onto the couch with her, positioning him on his stomach between herself and the back of the couch. The mother and child fell asleep and the mother did not awake again until noon, when she found the child unresponsive. The mother contacted emergency services, while one of the friends in the home began resuscitative efforts. The child was transported via ambulance to the hospital, where he was pronounced deceased at 12:45 PM.

From the time the investigation began to the time of its closure, OCDSS completed interviews with family members and relevant collateral sources. Serious concerns unrelated to the fatality arose regarding the mother's care of her children shortly after the investigation began, and OCDSS sought appropriate Family Court intervention. Law enforcement found no criminality regarding the child's death. OCDSS found no evidence to support the allegations related to the fatality; however, additional allegations pertaining to the other children in the home were substantiated. A CPS services case remained open and active at the time of this writing.

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:
OCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving sibling.

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 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: 01/06/2003 **Time of Death:** 12:45 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: 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? 3 Hours
At time of incident supervisor was: Unknown if they were 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	11 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	17 Year(s)

LDSS Response

On 12/4/19, OCDSS received the SCR report regarding the death of SC. The report received also had numerous concerns surrounding siblings born several years after SC's death; the allegations concerning those children were unrelated to those involving SC. OCDSS promptly reached out to LE and learned SC died 16 years ago and his date of death was 1/6/03. LE informed OCDSS an autopsy was performed, and the ME had determined the cause of death to be positional asphyxiation due to an unsafe sleep environment. Further, LE explained there were no criminal charges filed against SM, and an SCR report had not been made at the time of SC's death.

OCDSS completed a thorough CPS history check on the family and found there had been an open CPS investigation when SC had died in 2003. During that investigation, SM and SC had been living in a shelter for young mothers and were receiving an array of services through that agency. The CW at that time spoke at length with SM and shelter staff regarding the death of SC and contacted numerous collateral sources. The record did not reflect SC's death was the result of abuse or maltreatment. No SCR report was made at the time regarding SC's death.

On 12/5/19, OCDSS completed a home visit to SM's address and spoke with her about the fatality allegations. SM reported SC died due to positional asphyxiation, and on the date of his death she and SC had spent the night at a friend's house. SM reported she had been living at a parenting shelter at the time, but due to inclement weather on that day, she was unable to get back to the residence. SM informed OCDSS she had slept on her friend's couch with SC, and when she awoke, SC was unconscious. SM stated SC had a history of seizures and denied she ever harmed SC. SM reported she could not recall any other details surrounding the incident as it was so long ago, and she was very young.

On 12/9/19, OCDSS obtained the police incident reports and statements that were provided to LE the day of SC's death. LE interviewed SM and the two friends whose home SM and SC were staying at that night, The statements noted SM and SC arrived to their home at approximately 11:00 PM the night of 1/5/03, and SM was asleep on the couch and SC was asleep in his stroller before the friends went to bed around 5:00 AM the next morning. The friends explained before they went to bed, they noticed SC began to stir, so they propped a bottle on a towel beside him. The friends stated they did not hear anything else until around noon when SM began screaming. SM's statement was consistent with the facts the friends provided. SM explained she went to bed around 3:45 AM on 1/6/03, and at 8:00 AM, she brought SC out of his stroller and onto the couch with her. The statement noted SM fell asleep around 9:00 AM, and SC had been asleep beside her on his stomach. SM awoke around noon and found SC unresponsive. She contacted 911 and one of the friends in the home began CPR.

On 1/22/20, OCDSS obtained SM's prenatal records and SC's medical records, as well as records from the hospital on the date of his death. On 2/12/20, OCDSS spoke with the individual thought to be SC's father. He reported he and SM had broken up 6 months prior to SC's death, and paternity had never been established.

Throughout the investigation, OCDSS gathered information from collateral sources, including the ME and family

members regarding the death of SC. OCDSS also worked diligently to address the current concerns surrounding SM's children and took action to keep them safe. OCDSS appropriately determined the report. The investigation was closed, and a CPS services case was opened and ongoing at the time of this writing.

Official Manner and Cause of Death

Official Manner: Undetermined
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 Onondaga Multidisciplinary Team.

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
053941 - Deceased Child, Male, 11 Mons	053942 - Mother, Female, 17 Year(s)	DOA / Fatality	Unsubstantiated
053941 - Deceased Child, Male, 11 Mons	053942 - Mother, Female, 17 Year(s)	Inadequate Guardianship	Unsubstantiated
053941 - Deceased Child, Male, 11 Mons	053942 - Mother, Female, 17 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
053941 - Deceased Child, Male, 11 Mons	053942 - Mother, Female, 17 Year(s)	Lack of Medical Care	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:
OCDSS interviewed SM and appropriate collateral sources. 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?	☐	☒	☐	☐

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:
SM was receiving services at the shelter in which she resided at the time of SC's death. It was unknown if SM continued with the services after the investigation was closed.

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 surviving siblings at the time of SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS offered SM appropriate services following the death of SC.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)	Allegation Outcome	Compliance Issue(s)
08/04/2002	Deceased Child, Male, 5 Months	Mother, Female, 17 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 5 Months	Mother, Female, 17 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
This report was received with concerns SM was not properly caring for SC and would often leave him at friend's houses without provisions. There were further concerns SC had a severe diaper rash that was not being treated, and SM did not have stable housing.

Report Determination: Indicated	**Date of Determination:** 01/09/2003

Basis for Determination:
OCDSS completed interviews with SM and several collateral sources. There was some evidence found to substantiate the allegation of IG, as SM admitted to leaving SC with friends who had an extensive CPS history. OCDSS found SM had been treating SC's diaper rash and SC was up to date medically. SC was diagnosed with a medical condition that was treated with medication. OCDSS assisted SM with obtaining housing at a shelter for young mothers where she and SC began receiving an array of services. During this open investigation, SC died. OCDSS appropriately determined and closed the case.

OCFS Review Results:
This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/18/2002	Deceased Child, Male, 1 Months	Mother, Unknown, 17 Years	Lacerations / Bruises / Welts	Substantiated	No
	Deceased Child, Male, 1 Months	Mother's Partner, Male, 23 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Male, 1 Months	Mother, Unknown, 17 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Months	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This report was received with concerns SC had a bruise on his cheek and SM had no explanation. There were further concerns SM was seen kicking SC's car seat while he was inside of it because she was upset with her boyfriend. SC was sleeping in his car seat at night instead of his crib, and SM and her boyfriend had made statements they may hurt SC when angry.

Report Determination: Indicated	**Date of Determination:** 06/24/2002

Basis for Determination:
OCDSS interviewed SM, her boyfriend, and several collateral sources. There was some evidence found to substantiate the allegation of L/B/W due to SC having an unexplained bruise. OCDSS discovered SM's boyfriend at the time had made comments that he got so angry at times he was unsure if he would hurt SC. OCDSS assisted SM with obtaining a crib, and getting into parenting and anger management classes. At the close of the investigation, SM and her boyfriend had broken up, and SM and SC moved in with SM's mother.

OCFS Review Results:
This investigation met all statutory requirements. An administrative review overturned the substantiated allegation of IG.

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

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

There was no 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