Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-19-060

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

Issue Date: Jun 08, 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	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 12/26/2019
Initial Date OCFS Notified: 12/26/2019

Presenting Information

An SCR report alleged around 8:30 AM on 12/26/2019, the mother put the two-month-old infant in her bed. The mother laid down next to the infant and fell asleep with blankets and pillows on top of the bed. The father was at work during the time of the incident and he came home around 12:15 PM. The father saw the mother and infant in the bed, and the infant was unresponsive. The father called 911 at that time and EMS responded. EMS attempted to revive the infant on the way to the hospital. The infant died as a result of co-sleeping with the mother and was pronounced dead at 1:05 PM. The father had an unknown role.

Executive Summary

On 12/26/19, the Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report regarding the death of the two-month-old male infant. The infant was the father's only child and the mother had two other children, ages 16 and 14, who resided with their father.

OCDCFS conducted a joint investigation with law enforcement and learned that on 12/26/19, the mother laid down with the infant in her adult bed around 8:30 AM. The father arrived home from work at 12:15 PM and discovered the infant was unresponsive underneath a pillow that the mother was sleeping on. The father immediately performed CPR and the mother called 911. EMS responded and transported the infant to the hospital via ambulance. Attempts to resuscitate the infant were not successful and he was pronounced deceased by the emergency room physician at 1:05 PM.

An autopsy was performed, and the medical examiner reported there was no trauma, congenital anomaly or acute disease process to account for death. The cause of death was determined to be unexplained sudden death of infant (intrinsic and extrinsic factors identified.) The contributory factors surrounding the infant's death were a history of premature birth and an unsafe sleep environment: bedsharing. The manner of death was undetermined. Law enforcement closed their investigation with no criminal charges filed.

OCDCFS thoroughly investigated the infant's death through interviews with the parents and collateral contacts. It was learned that the mother and father were engaged in opiate maintenance programs and the mother took her prescribed medication around 5:00 AM. First responders reported the mother did not appear impaired, although the father reported that the mother slept more soundly when she took her medication. The parents were aware of safe sleep guidelines and had a bassinet for the infant to sleep in, although the mother said she occasionally co-slept with the infant in the adult bed with pillows and blankets. OCDCFS appropriately substantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother.

OCDCFS contacted Madison County CPS on 12/26/19, and requested that they assess the safety of the siblings at their father's home. It was not documented if a home visit was conducted or if the siblings or their father were spoken to. OCDCFS incorrectly checked off that there were no surviving children and, therefore, a Risk Assessment Profile and Investigation Determination Safety Assessment were not completed.

The mother received emergency mental health treatment on the night of the infant's death and the parents remained engaged in opiate maintenance programs at the time the case closed. The record did not reflect that bereavement services or funeral assistance were offered to the parents.

PIP Requirement
OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS 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:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** No
- **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:
OCDCFS did not document that the safety of the siblings was assessed and an Investigation Determination Safety Assessment was not completed.

Was the decision to close the case appropriate? No

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The decision to indicate the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The siblings' safety was not assessed and their father was not spoken to.
Legal Reference:	432.1 (o)
Action:	OCDCFS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities

	with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	OCDCFS inaccurately documented there were no surviving children and a Risk Assessment Profile was not completed regarding the siblings.
Legal Reference:	18 NYCRR 432.2(d)
Action:	OCDCFS will assess risk for all children and will accurately document any risk elements identified into the Risk Assessment Profile .
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	OCDCFS did not complete the Investigation Determination Safety Assessment.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	OCDCFS will conduct an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and document such assessment in the form and manner provided by OCFS.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/26/2019 **Time of Death:** 01:05 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: 12:16 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	2 Month(s)
Deceased Child's Household	Father	No Role	Male	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)

LDSS Response

OCDCFS began their investigation upon receipt of the SCR report on 12/26/19. They contacted the source of the report, searched SCR history, notified the DA's office of the infant's death and provided the required Notice of Existence Letters to the parents. OCDCFS interviewed the father at home and then interviewed the mother at a psychiatric center. OCDCFS contacted Madison County CPS to assess the surviving siblings' safety, although they did not document if they followed up on this request. At the conclusion of the investigation, it was unclear if the safety of the siblings was assessed in their father's care.

Through interviews with the parents, it was learned that the infant was born at 34 weeks gestation via emergency c-section and he had a positive toxicology for the mother's prescribed medication. The infant remained in the Neonatal Intensive Care Unit for three weeks. The infant was healthy, although he was often fussy, and he was not on any medication. The father reported the mother slept soundly on her medication and she often did not wake up when the infant cried. The parents were aware of safe sleep guidelines and reported the infant slept in a co-sleeper on the bed, in a bassinet, or occasionally in bed with them. The mother reported her two older children resided with their father and she had brought the infant to meet them for the first time on 12/25/19. It was not documented how frequently the mother visited with the children.

The parents reported that on the night of 12/25/19, the mother got up twice to feed and change the infant and he was fussy. The second time the mother got up she did not go back to bed. She woke the father at 5:00 AM and she took her medication and a shower. The father left for work at 6:40 AM, and the infant was in his bouncy seat at that time. Around 8:30 AM, the infant became fussy so the mother gave him gas drops, wrapped an infant heating pad around his stomach, swaddled him, and then laid him on his back on the adult bed. The mother laid down next to him and she fell asleep. The father tried calling the mother during his morning break, as he always did, and she did not answer. He continued to call every 10 minutes since it was unlike the mother not to answer the phone. He became concerned and he left work to go home and check on the mother. He arrived home at 12:15 PM, and he found the mother sleeping with her head and chest on top of a pillow. The infant was face-up underneath the pillow, and he was unresponsive. The father immediately woke up the mother and he brought the infant into the living room and performed CPR. The mother called 911 and she was very distraught. The mother received emergency mental health treatment for suicidal ideation on the night of 12/26/19.

There were no safety hazards present in the home and the appropriate supplies were observed for the infant. The adult bed was observed to have blankets, pillows and a baby bottle. There was a bassinet and a co-sleeper observed in the parents' bedroom and a portable crib in the living room that had several items in it.

OCDCFS gathered information from law enforcement, the DA's office, the medical examiner, the pediatrician, hospital

staff, the father's substance abuse treatment provider and the mother's obstetrician. Information gathered was consistent with the infant being born pre-mature and with him being healthy and up-to-date on well-child examinations. Records gathered stated that the infant was found unresponsive while co-sleeping with the mother and he arrived at the hospital in cardiac arrest. The infant was found to have no injuries and it was determined the unsafe sleep environment contributed to his death.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a 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
054061 - Deceased Child, Male, 2 Mons	054062 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
054061 - Deceased Child, Male, 2 Mons	054062 - Mother, Female, 37 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
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:

Although OCDCFS contacted Madison County CPS to request they assess the safety of the siblings, it was not documented that the children or their father were spoken to.

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?	☐	☐	☒	☐

Explain:
Within 24 hours, OCDCFS learned that the mother had two other children and they requested that Madison County assess their safety. The 24-Hour and 7-Day Safety Assessments stated that the siblings' safety would be assessed by Madison County, although there was no documentation that the children were seen or that their father was spoken to.

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:
The RAP was not completed as it was inaccurately documented that there were no surviving children. Risk to the surviving siblings was not assessed and service needs related to the fatality were not explored with the mother, father, or the father of the siblings.

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?	☐	☒	☐	☐

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:
The mother was provided with emergency mental health services following the infant's death and the parents continued in substance abuse treatment. Service needs related to the fatality were not explored.

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? Unable to Determine
Explain:
There was no documentation if the mother's two older children were spoken to or if they had any service needs as a result of the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother received emergency mental health services.

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

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

Two SCR reports were received on 1/28/13 that were unsubstantiated against the mother for the allegations of Inadequate Guardianship and Parent's Drug/Alcohol Misuse regarding a niece.

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