Child Fatality Report

Report Identification Number: SY-16-056

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

Issue Date: Mar 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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 11/09/2016
Initial Date OCFS Notified: 11/09/2016

Presenting Information

On 11/9/2016 the SCR received two reports regarding the death of the four-month-old male SC. The initial report alleged the SC had been in the care of the SM and SF when the SC was found by the SF, unresponsive on the couch. The subsequent report alleged the SC was in the sole care of the SF when SF found the SC unresponsive in his crib, after he had heard the SC crying. It was alleged that when help arrived approximately an hour and fifteen minutes later, the SC showed signs of rigor mortis indicating he had been deceased for a substantial period of time. Reports further stated the SC was an otherwise healthy child with no prior medical history.

Executive Summary

An SCR report was received by Oneida County Department of Social Services (OCDSS) on 11/9/2016, reporting the death of the otherwise healthy 4-month-old SC. The report alleged that the SC had been in the care of SM and SF when SC was found by SF, unresponsive on the couch. The allegations were DOA/Fatality and IG against both parents. A subsequent report was received later the same day, though it alleged the SC was in the sole care of SF when SF found SC unresponsive in his crib. It was alleged that when help arrived approximately an hour and fifteen minutes later, SC showed signs of rigor mortis indicating he had been deceased for a substantial period of time. The allegations of DOA/Fatality and IG in the subsequent report were made against SF only.

OCDSS immediately checked for any Child Protective history and learned there was none for the SM, SF, or the SC. OCDSS then coordinated with LE who already had a substantial amount of information surrounding observations of the SC, information provided by the alleged subjects, and observations of the address where the incident occurred. OCDSS also confirmed there were no SS, other children, or other adults living in the home.

OCDSS interviewed the SF and SM separately on the date of the report. SF explained he fed the SC after SM left for work (at approximately 5:45AM) and then he changed, burped, and rocked the SC back to sleep (until around 7AM). The SF awoke to the child crying in the bassinet that was attached to the Pack and Play at about 10:30AM, but went to the bathroom prior to checking on the child for approximately a half an hour. When SF went back into the room where the child had been sleeping, SF found the SC not breathing. The SF reported he panicked and called SM and then the maternal grandparents, but could not get through. He then called the SM's workplace, and the person on the phone suggested he try CPR and wait for EMS to arrive. The SF believed someone at SM's workplace called 911 while he attempted CPR.

OCDSS interviewed SM and learned the baby was fine prior to her leaving for work and she was not present when the child passed away. The SM did not have any concerns for the SC in SF's care, and he was a regular caretaker for the SC while the SM worked. The SM did not suspect the SF did anything to harm the baby.

OCDSS corresponded with LE throughout the investigation and learned there were to be no criminal charges against either parent as a result of the fatality due to no evidence of any foul play. There were multiple case conferences between the CW and the MDT Supervisors regarding information obtained relevant to the fatality. Timely and accurate safety assessments were completed, which noted no safety concerns due to the fact that there were no SS or other children in the home.

Based on observations that the child was placed in the bassinet, swaddled on his stomach, and had a comforter rolled into a thick U-shape on three sides of the bassinet, OCDSS felt that an unsafe sleep environment could have been a contributing factor to the SC's untimely death. This was also the child's usual sleeping arrangement. OCDSS obtained the final autopsy report and learned that the cause of death was suffocation due to an unsafe sleep environment, and the manner of death was accidental. At the time of this report, the case has yet to be closed, though the record reflects that OCDSS plans to substantiate the allegations against SF.

The CW provided information on bereavement and burial services to both parents individually. The parents accepted the
information but it is unknown if they utilized any services. OCDSS completed home visits and adequately completed all casework activity relevant to the fatality investigation.

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?** — Unable to Determine

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?** — Unable to Determine

Explain:
The case remains open at the time of this report; however, OCDSS has documented a sufficient amount of information to make a determination of the allegations. Although the Determination Safety Assessment has yet to be completed, OCDSS has documented the non-existence of any SS or other children which will influence their final assessment of safety.

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:
All casework activity was commensurate with case circumstances, and the case record has detailed documentation of consultations with supervisors.

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: 11/09/2016 **Time of Death:** 11:51 AM

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

County where fatality incident occurred: ONEIDA
Was 911 or local emergency number called? Yes
Time of Call: 11:46 AM
Did EMS to 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
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

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	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

On 11/9/2016 upon receipt of the SCR report, OCDSS coordinated with LE and gathered pertinent information related to the fatality; specifically, LE's observations of the SC, information provided to LE by the alleged subjects, and LE's observations of the home where the incident occurred. OCDSS interviewed the SF and SM alone and separately after LE's interviews. SF provided a timeline leading up to the death of SC. SF informed OCDSS that the child was crying in the bassinet that was attached to the Pack and Play at about 10:30AM, and when he returned from the bathroom approximately a half an hour later, he found the SC to be not breathing and face-down in the mattress. OCDSS learned from SM that the baby was fine prior to her leaving for work and she was not present when the child passed away. The CW provided the

parents with information on bereavement and burial services.

Based on the information that OCDSS obtained throughout their investigation, an unsafe sleeping environment was considered as a contributing factor to the otherwise healthy child's untimely death. SF reported when he put the child to sleep, he swaddled the SC and placed him on his stomach in the bassinet feature attached to the Pack and Play. There was also a comforter, rolled into a thick U-shape, placed on three sides of the bassinet. When SF found the SC unresponsive, he was face-down in the mattress with the previously swaddled blanket down near his feet. CW addressed safe sleep practice with the parents. The parents acknowledged that upon the SC's birth, hospital staff spoke with them about the dangers of co-sleeping but they denied having knowledge about the dangers of other objects in the sleeping environment.

OCDSS obtained the final autopsy report and learned from the ME that the official cause of death was suffocation due to an unsafe sleep environment, the manner of death accidental.

Timely and accurate safety assessments were completed, which noted no safety concerns due to the fact that there were no SS or other children in the home. OCDSS corresponded with LE throughout the investigation and learned there were to be no criminal charges against either parent as a result of the fatality due to no evidence of any foul play. There were multiple case conferences between the CW and the MDT Supervisors regarding information obtained relative to the fatality.

OCDSS gathered information from relevant collateral contacts, including first responders, the SC's pediatrician, and hospital birth records. The SC's pediatrician reported the child was last seen on 9/18/2016 for a well child exam and child had normal growth and development with no concerns noted. There were no birth-related complications appearing to have contributed to his condition. OCDSS learned that when EMS arrived, the SC was in asystole and was pronounced dead at the scene.

The Child Protective case remains open at the time of this report, though the record reflects that OCDSS plans to substantiate the allegations against SF.

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: The investigation was conducted jointly between Oneida County CPS and the Rome Police Department.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The case is planned to be reviewed at the next CFRT meeting.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

032204 - Deceased Child, Male, 4 Mons	033902 - Father, Male, 28 Year(s)	DOA / Fatality	Pending
032204 - Deceased Child, Male, 4 Mons	033901 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Pending
032204 - Deceased Child, Male, 4 Mons	033902 - Father, Male, 28 Year(s)	Inadequate Guardianship	Pending
032204 - Deceased Child, Male, 4 Mons	033901 - Mother, Female, 24 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

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	Needed but not Offered	Needed but Unavaliable	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:
OCDSS provided both parents with individual packets for bereavement supports and burial services, which both parents accepted but it is unknown if it was used. SF identified mental health diagnoses and SF said he was not interested in any mental health services. As there were no surviving siblings or other children in the household, there was no need for offering of additional 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? N/A
Explain:
There were no surviving siblings or other children in the household to which OCDSS would have needed to provide services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There were no services provided to the parents, as no immediate needs related to the fatality were identified. The parents did accept individual bereavement support packages provided by OCDSS in the event that they wished to participate in

any services.

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?	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

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 history for SM, SF or SC prior to this fatality investigation.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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