Child Fatality Report

Report Identification Number: SY-17-032

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

Issue Date: Dec 11, 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	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: Oswego
Gender: Male
Date of Death: 07/15/2017
Initial Date OCFS Notified: 07/15/2017

Presenting Information

The SCR received a report alleging on 7/15/2017, the SM put the 3-month-old SC down for a nap around 5:00 PM in his Pack and Play. The SM also took a nap in her own bed at the same time. The SM awoke at 7:00 PM and went to check on the SC. The SC was found deceased by the SM in his Pack and Play. The SC's death was suspicious in nature as he was an otherwise healthy child. At the time of the incident, the SC was in the care of both the SM and SF, making them both alleged subjects.

Executive Summary

On 7/15/2017, an SCR report was made regarding the death of the 3-month-old SC. Oswego County Department of Social Services (OCDSS) was assigned to the investigation, which occurred collaboratively with the New York State Police Department.

OCDSS met LE at the family's home, which was where the fatality occurred. The CW observed the deceased SC in his portable crib, where he had been found by the SM at 7:00 PM. LE informed OCDSS the SC was found by SM on his stomach with his face pressed into the mesh lining, between the mesh and a foam mattress pad inside the crib. The foam pad was used in addition to the pad that typically accompanies portable cribs. In an interview, SM admitted there had been previous times when she had to move the SC out of a similar position. Photos showed there was approximately a 2-inch gap between the foam padding and the mesh, along with a loose sheet underneath the SC. OCDSS contacted a service provider, who stated she had discussed safe sleep practice with the SM prior to the fatality, but recalled never having observed the sleep environment despite previous home visits. The crib had been provided to the parents by a different service provider. In acknowledgement of their use of the extra foam padding, the parents reported the padding had come with the portable crib that was provided to them. OCDSS contacted the two different service providers, neither of whom had inspected the crib for safety.

SM and SF were interviewed separately at the police station, and OCDSS was present. SM gave a consistent account of how she found the SC, in addition to a timeline of events leading up to the fatality. The SM had placed the SC in the portable crib on top of the foam mattress pad and loose sheet, with no blankets, at 5:30 PM. At 6:00 PM, she saw that he was asleep, and she took a nap in her own bed. She awoke at 7:00 PM, at which point she found the SC wedged in the side of the crib, unresponsive. She called to the SF who was in the home, and called 911. It was not evident that either parent attempted CPR, and the SF covered the SC up with a pillowcase. EMS responded to the home and pronounced the SC dead on arrival. The SC's skin was discolored as a result of the blood pooling from positioning, and his arm was in a fixed position due to rigor mortis. LE commented that despite the discoloration, there appeared to be no obvious signs of bruising.

The autopsy report noted the cause of death was asphyxia, and the manner was undetermined. The report revealed rib fractures which occurred prior to death. It was discussed that a vaginal birth could have been a plausible explanation for the fractures, though the SC was delivered via cesarean section. LE re-interviewed the SM after the final autopsy was received, and attempted to re-interview the SF though he refused, citing he had obtained a lawyer. SM denied she inflicted harm and discussed a time within weeks of SC's death where the SF hugged and squeezed the crying SC, who cried worse afterword, and expressed concern to SF that he had hugged him too hard; however, SM took no further protective measures. LE continued to investigate the criminality of this matter, and their case remained open.

OCDSS learned there were no surviving children in either parents' care. The SC had been SM's first child, and the SF had two children with two other mothers, both to whom he no longer had any parental rights. OCDSS completed timely and accurate safety assessments, and sufficiently followed up on collateral contacts to learn information related to the fatality. OCDSS offered grief counseling through the CAC and MH services, as well as assistance with burial costs (though the family was denied that assistance). OCDSS had not determined the report at the time of this fatality report, though it was noted there was credible evidence to substantiate all allegations and the determination was pending approval. OCFS' review revealed no concerns with the pending decisions.

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?** N/A

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?** N/A

Explain:
The CPS investigation remained open at the time this report was written, pending closure.

Was the decision to close the case appropriate? N/A

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 CPS investigation remains open. Since the investigation began, casework activity has been commensurate with case circumstances and there was documentation of supervisory consultation.

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: 07/15/2017 **Time of Death:** 07:13 PM

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

County where fatality incident occurred: Oswego
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? Unknown
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? 1 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Father	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDSS met LE at the family's residence where SC was found deceased. OCDSS observed the scene, later secured photographs taken by LE, and gathered criminal background information. OCDSS searched CPS history and found SF previously had his parental rights terminated to children he had with other mothers due to neglect (exceeding 10 years prior). A 24-hour safety assessment accurately reflected there were no safety concerns, as neither parent had children remaining in their care.

Both parents were interviewed by LE in the presence of OCDSS. SM, who was the last person to see SC alive, reported he slept at various points throughout the day, the last time being at 6PM. During the last interval of napping, she slept on her own bed and awoke at 7PM, at which time she checked on SC and found him unresponsive. She reported SC was between the mattresses and the crib lining, facing the outside of the crib. She stated she flipped him over, yelled to SF that SC was

dead, and SF came in and placed a pillowcase over him. SM reported SC was not ill and had not taken medications that day. She had difficulty remembering the last time she gave him his prescribed medication. SM believed the last time she administered it was four days prior because he was "fussy," and she "wanted him to sleep." An infant medication syringe was found at the home, with residue of what appeared to be the prescribed medication in the tip.

SM and SF both stated SF was in and out of the home all day. SF reported he was in the home at the time of the incident after coming inside between 6PM and 6:30PM. SF said he called to SM to check on SC while he went to prepare bottles. SF said he ran into the room when SM screamed that SC was "gone," and saw that SC was blue. It was reported SM called 911, and already had them on the phone when she came out screaming. SF stated he responded by hitting the walls and going outside to scream.

Interviews revealed SM had history of drug abuse, criminal activity, and MH issues. SM described current medications she had been taking for MH diagnoses, and denied drug or alcohol use at the time of the incident. SM said SF had a beer that day. SF said he would never drink if caring for the SC. SF reported he regularly took medications for medical problems, and denied any MH diagnoses. It was revealed both parents were limited cognitively. Both denied domestic violence, or doing anything to hurt SC. It was noted SM urinated on herself during the interview despite being offered the opportunity to use the restroom.

The day after the fatality, OCDSS learned rib fractures were found during the autopsy. Once this was confirmed, LE re-interviewed SM. SM believed they could have been sustained from SF "hugging" the SC too hard at a time he was extremely fussy. Efforts were made to re-interview SF though he refused, noting he had a lawyer. OCDSS contacted service providers for collateral contacts. The family received assistance through the Pregnancy Care Center and the OPTIONS program. It was revealed the OPTIONS worker had verbally discussed safe sleep with SM prior to the fatality, and SM stated she was informed about safe sleep.

The parents were offered grief counseling and assistance with burial costs. They had requested assistance with cremation costs but were reportedly ineligible. During a home visit a month after the fatality, the parents described suffering MH conditions related to the trauma. The parents stated they were involved with grief services. The parents showed OCDSS a crib, a mattress, and clothes; SM stated they were trying to have another baby to "fill the void." SM described she was still involved with her care manager, and both parents stated they would never use a portable crib again. Though safe sleep practice was discussed in initial interviews, CW did not reiterate at this point that the danger had not been the portable crib, but the added contents inside it. Investigation remained open.

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042042 - Deceased Child, Male, 3 Mons	042044 - Father, Male, 47 Year(s)	Inadequate Guardianship	Pending
042042 - Deceased Child, Male, 3 Mons	042044 - Father, Male, 47 Year(s)	DOA / Fatality	Pending
042042 - Deceased Child, Male, 3 Mons	042043 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending
042042 - Deceased Child, Male, 3 Mons	042043 - Mother, Female, 35 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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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:

Statements of first responders were obtained from LE. Parents were asked to provide family members for collateral contacts though they refused.

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 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:
OCDSS offered assistance with burial costs but parents requested assistance with the cremation; SF stated they were contacted but not eligible. Parents discussed MH issues as an impact of the fatality then stated they were trying to have another baby to fill the void, and SM stated she continued to work with the OPTIONS worker (a family planning/health care service).

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 children in need of services regarding the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief counseling was provided through the CAC. The parents were denied assistance with burial/cremation costs.

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?	Yes
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

1/20/2004-3/3/2004 SF was a confirmed subject regarding his then 4-month-old child, along with that child's mother. The confirmed allegations against the parents was inadequate guardianship. There were concerns for limited parenting skills, alcohol and prescription drug abuse, and physical violence in the presence of the child. SF also had a history of sexual misconduct with a minor which occurred prior to age 21, though there was no evidence he perpetrated again. As a result of the concerns which placed the child in immediate/impending danger of serious harm, the child was voluntarily removed and services were put in place. Eventually the parents surrendered their rights and the child was adopted.

10/21/1999-12/15/1999 Another child to whom SF was the biological father was removed from his mother upon birth in 1999. A neglect petition was filed, though the SF was not indicated as a subject due to lack of credible evidence. During the recent investigation, agency staff informed the investigating caseworker that the SF's parental rights to this child were terminated as of 5/17/2001 following a finding of permanent neglect.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Preventive Services History

SF and the mother of one of his children were provided preventive services upon the voluntary removal of their child in 2004, including MH, substance abuse and DV counseling, parenting and anger management classes, case management, and supervised visits. Significant concerns continued despite interventions, and eventually the SF and the mother surrendered their parental rights, freeing the child for adoption. The preventive services case subsequently closed 9/14/2005.

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

Action:	Based on review of information obtained from this fatality investigation, OCFS recommends OCDSS work with their local Child Fatality Review Team to see that service providers who distribute cribs to the public are inspecting them for safety prior to dissemination.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No