Child Fatality Report

Report Identification Number: SY-20-053

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

Issue Date: May 24, 2021

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: 3 month(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 11/25/2020
Initial Date OCFS Notified: 11/25/2020

Presenting Information

An SCR report was received which alleged that on 11/25/20, the father arrived home around midnight and found the mother asleep on the couch, and the three-month-old subject child fussing in his crib. The father fed the child and then placed the child in bed with him. The father propped pillows around the child and proceeded to co-sleep. Several hours later, the father awoke to find the child unresponsive. The mother called for an ambulance. The father admitted to regularly using marijuana; however, it was unknown if he had used that day.

Executive Summary

This fatality report concerns the death of a three-month-old male subject child that occurred on 11/25/20. A report was made to the SCR on that same date with allegations of Inadequate Guardianship, Parent's Drug/Alcohol Misuse, and DOA/Fatality against the child's mother and father. Oneida County Department of Social Services (OCDSS) received the report and investigated the child's death. An autopsy was completed, and the cause of death was listed as "asphyxia due to wedging." The manner of death was ruled an accident.

At the time of the child's death, he resided with his mother and father. There were no surviving siblings or other children in the household. The investigation revealed that on the night of 11/24/20, the father returned home from work at approximately 10:00PM, and found the mother asleep on the couch and observed the child to be asleep in the parents' bedroom, in their bed. The father left the residence to buy marijuana, and used the substance prior to returning home, around 1:00AM. The father tended to the child upon his return, as the child was fussing and crying and the mother remained asleep on the couch. The father then laid with the child in the adult bed and unintentionally fell asleep beside him. The mother awoke to find the father and child in bed together, and the child's face pressed into the father's left side, unresponsive. Emergency services were called and responded to the home. The child was pronounced dead at the scene at 8:00AM.

From the time the investigation began to the time of its closure, OCDSS interviewed family members and collateral sources. It was determined the parents had been educated several times surrounding safe sleep practices. The parents were arrested and charged with endangering the welfare of a child due to both using marijuana in the hours leading up to the child's death. OCDSS found a causal link between the parent's drug use prior to placing the child in an unsafe sleeping environment and the fatality, and therefore substantiated the allegations and closed the case.

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 information to determine the allegations in the report. There were no surviving siblings or other children in the household.

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: 11/25/2020 **Time of Death:** 08:00 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: 07:44 AM
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? 6 Hours
At time of incident was supervisor impaired?
☒ Drug Impaired ☐ Alcohol Impaired

☐ Impaired by illness
☐ Impaired by disability

At time of incident supervisor was:

☐ Distracted
☐ Absent
☒ Asleep
☐ 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	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)

LDSS Response

On 11/25/20, OCDSS received the SCR report regarding the death of SC, which occurred on that same date. OCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. SC was an only child, and there were no other children residing in the household.

On 11/25/20, OCDSS met with the parents at their home. OCDSS observed a crib in the parents' bedroom with stuffed animals inside. OCDSS spoke with SF, who reported the previous day, he had gotten called into work at 4:00PM, and SM had stayed at home with SC. He said he arrived home from work around 10:30PM and found SM asleep on the couch. SF stated he attempted to rouse her, and she would wake up but quickly fall back to sleep. SF stated he went into the bedroom and found SC laying on SF and SM's bed asleep; SC was "alive and well." SF stated his nightly routine was to smoke marijuana before he went to bed, but he had none, so he left the home to buy more and picked up his brother and a coworker on the way. SF stated they all smoked "dabs" and bowls, and then he dropped each back off to their homes before going home himself; he arrived around 1:00AM. SF stated when he walked into the house, SC was crying and SM was still asleep on the couch. He said he changed SC's diaper, fed him, and then put him back into the adult bed. SF reported he propped SC up on pillows, so he was sitting up, surrounded him with a 'Boppy'pillow, and tucked a blanket around him. SF said he laid down with SC, and did not intend to fall asleep, but did. SF reported SM woke him up around 7:30AM and they found SC's face pressed into SF's left side; SC was not breathing, and purple in color. SF said they called 911 and performed CPR until the fire department arrived. He reported he and SM did not normally co-sleep with SC.

On 11/25/20, OCDSS interviewed SM. SM's account of events corroborated that of SF's. She said around 8:00PM, she placed SC in her and SF's bed to sleep. SM stated she propped SC up on pillows because she wanted him elevated in case he vomited. SM reported she left SC in the bed to sleep and went and laid on the couch, where she unintentionally fell asleep; she was unsure what time SF returned home. SM stated she awoke around 7:40AM, and when she went to wake up SF, she found SC beside him, not breathing. SM admitted she also smoked marijuana and had last smoked before SF left for work on 11/24/20.

SM and SF agreed to a drug screening; however, did not show for their appointment and refused to reschedule. The parents were previously educated surrounding safe sleep. and SM said she was advised by her visiting nurse to prop up SC while he slept. On 11/25/20, OCDSS spoke with the visiting nurse, who explained she discussed safe sleep with the parents at

each visit and never told them to prop SC while he slept. The nurse said she advised the parents to prop him for 15 minutes after feedings to ease his reflux, and that he should always be supervised during this. She further explained she was working with the parents on SC's feeding schedule. The nurse denied ever witnessing the parents under the influence and or any drug paraphernalia in the home.

On 12/10/20, OCDSS received SC's medical records. It was noted SC was born prematurely and SM received morphine during labor; therefore, SC had a positive toxicology at birth. There were no complications noted. SC was last seen medically on 11/6/20 with no concerns documented.

Collateral sources revealed SF had smoked a significant amount of marijuana shortly before co-sleeping with SC, and SM admitted to regularly using marijuana while caring for SC. On 1/21/21, both were charged with EWOC.

Throughout the investigation, OCDSS spoke with family members, LE, first responders, medical providers, and the ME. Services were offered but declined. OCDSS found evidence that the parents' actions placed SC in imminent danger and risk of harm. The report was indicated and closed.

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 Oneida County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056989 - Deceased Child, Male, 3 Mons	056990 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
056989 - Deceased Child, Male, 3 Mons	056990 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
056989 - Deceased Child, Male, 3 Mons	056990 - Mother, Female, 20 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
056989 - Deceased Child, Male, 3 Mons	056991 - Father, Male, 23 Year(s)	DOA / Fatality	Substantiated
056989 - Deceased Child, Male, 3 Mons	056991 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
056989 - Deceased Child, Male, 3 Mons	056991 - Father, Male, 23 Year(s)	Parents Drug / Alcohol Misuse	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:
OCDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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?
☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
01/27/2021	SM and SF	Unknown	Unknown
Comments:	Due to the parents using marijuana in the hours leading up to the child's death, both were arrested and charged with endangering the welfare of a child.		

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:
OCDSS offered the parents services in response to the death of the child, as well as information regarding funeral cost assistance. Substance abuse treatment referrals were provided; however, the parents declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS offered the parents referrals for grief counseling as well as funeral cost assistance.

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? 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 was 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