Child Fatality Report

Report Identification Number: SY-22-019

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

Issue Date: Oct 14, 2022

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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 1 year(s)
Jurisdiction: Oswego
Gender: Female
Date of Death: 04/22/2022
Initial Date OCFS Notified: 04/23/2022

Presenting Information

An SCR report was received with concerns that on 4/22/22, the mother was visibly impaired by an unknown substance when she operated a vehicle with the one-year-old subject child as a passenger. While the mother was driving, she went off the road and hit a tree, causing the vehicle to flip and crash. Emergency services were called, and the subject child was transported to the hospital, where she underwent neurosurgery to address her injuries. The subject child was pronounced deceased at 11:55PM on 4/22/22.

Executive Summary

This fatality report concerns the death of a one-year-old female subject child that occurred on 4/22/22. A report was registered with the SCR on that same date, while the subject child was still alive and placed on a ventilator. The child died on that same date, and a fatality report was registered with the SCR on 4/23/22 with allegations of Internal Injuries, Parent's Drug/Alcohol Misuse, and DOA/Fatality against the child's mother. Oswego 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 noted as "blunt force craniocerebral trauma due to car crash." The manner of death was accident.

At the time of the child's death, she resided with her mother and father. There were no surviving siblings or other children in the household. The investigation revealed that on the afternoon of 4/22/22, the mother was driving with the subject child as a passenger, when the mother lost control of the vehicle. The vehicle struck an earth embankment and several trees. The mother was uninjured; however, the subject child sustained life-threatening head and neck injuries in the crash. The subject child was transported via ambulance to the hospital where she later died. The child was pronounced deceased at 11:55PM on 4/22/22.

It was discovered the child was properly restrained in a car seat in the back of the vehicle at the time of the accident, and only the mother and child were in the vehicle at the time of the incident. The mother was found to have a blood alcohol content of .10% and was arrested and charged with first degree vehicular manslaughter, aggravated driving while intoxicated, and endangering the welfare of a child. The record did not reflect any further details surrounding what occurred, or the events leading up to such as neither the parents nor law enforcement were interviewed regarding the allegations in the report. There was no additional information documented about the criminal investigation. OCDSS offered the parents services following the fatality, but they declined. The investigation had not yet been determined at time of this writing; however, there was no explanation noted in the record as to why the case remained open.

PIP Requirement
This review resulted in a citation related to casework practice. In response, OCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
The investigation had not yet been determined at the time of this writing. There were no surviving siblings or other children in the household, therefore a safety assessment was not required.

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:
There were no surviving sibling or other children in the household. The investigation had not yet been determined at the time this report was issued.

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 record did not reflect if the allegations in the report were explored with either parent.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	OCDSS will make efforts to facilitate information gathering and analysis of safety factors, analyze the inter-relatedness of risk influences and individual risk elements affecting family functioning, and reach a determination on the allegations reported to the State central register.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Many progress notes (12 out of 31) were entered more than one month past event dates.
Legal Reference:	18 NYCRR 428.5
Action:	OCDSS will enter progress notes contemporaneously as events occur, including carrying over notes which reflect duplicate casework completed in concurrent investigations.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect any attempts to speak with first responders or hospital staff as collateral sources, or if the incident was fully explored with law enforcement.

Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/22/2022 **Time of Death:** 11:55 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? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☒ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ 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	Female	1 Year(s)
Deceased Child's Household	Father	No Role	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

On 4/24/22, OCDSS spoke with MGF via phone as a collateral contact. MGF reported SM was hospitalized due to her mental health following SC's death. He stated LE was treating SM like a "drug addict," and denied SM had ever used drugs. MGF explained what happened was an accident, and SM was not under the influence. MGF denied any concerns surrounding SM or her care of SC.

Early into the investigation, OCDSS was asked by LE not to interview the parents without the lead detective present;

however, the detective would not be available to do so for several weeks. OCDSS agreed to the request since there were no surviving siblings or other children in the household.

On 5/16/22, OCDSS spoke with LE and was informed SM's blood alcohol level was .10. LE explained SM was scheduled to meet with detectives on this date; however, she had not been returning any phone calls. LE stated SM would be arrested while at the station if she showed. The record did not reflect any further follow-up with LE regarding a joint interview with SM, or if OCDSS could move forward with interviewing the parents about the report. The record noted a news article that stated SM was arrested in June 2022 for aggravated DWI and vehicular manslaughter; however, it was not documented if this was confirmed with LE.

OCDSS made several attempts to meet with SM and BF by conducting unannounced home visits and phone calls. The record did not reflect the lead detective was present during the attempted home visits. On 8/16/22, OCDSS was able to speak with SM briefly on the phone; however, the record did not reflect any questions were asked about the allegations in the report. During this phone call, SM informed OCDSS that she had moved out of the county and refused to meet with OCDSS face to face. On this same date, OCDSS also spoke with BF via phone. BF reported he had not spoken to SM since SC's death. The record did not reflect if any questions were asked surrounding the allegations in the report.

Services were offered to SM and BF, but they declined. Although all casework activities were completed and OCDSS obtained sufficient evidence to make a determination and close the case, the investigation remained open at the time of this writing.

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 Oswego County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality investigation was submitted for review by the Oswego County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061574 - Deceased Child, Female, 1 Yrs	061575 - Mother, Female, 23 Year(s)	DOA / Fatality	Pending
061574 - Deceased Child, Female, 1 Yrs	061575 - Mother, Female, 23 Year(s)	Internal Injuries	Pending
061574 - Deceased Child, Female, 1 Yrs	061575 - Mother, Female, 23 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
The record did not reflect if OCDSS spoke with first responders. A home visit and face to face interview with the mother were attempted but unsuccessful. The father was interviewed via phone.

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: Vehicular manslaughter	**Degree:** 1		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Subject Mother	Pending	Pending

Comments:	The mother was arrested and charged with first degree vehicular manslaughter, aggravated driving while intoxicated, and endangering the welfare of a child.

Criminal Charge: Other - Aggravated DWI	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
06/22/2022	Subject Mother	Pending	Pending
Comments:	The mother was arrested and charged with first degree vehicular manslaughter, aggravated driving while intoxicated, and endangering the welfare of a child.		

Criminal Charge: Endangering the welfare of a child	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
06/22/2022	Subject Mother	Pending	Pending
Comments:	The mother was arrested and charged with first degree vehicular manslaughter, aggravated driving while intoxicated, and 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 and maternal grandfather service referrals for grief counseling but they declined. The record did not reflect if funeral cost assistance was discussed with the family.

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.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
OCDSS offered the family referrals for services several times during the investigation, but all declined.

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

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