Report Identification Number: SY-22-044

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

Issue Date: Apr 03, 2023

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 had an open investigation or a CPS monitored services 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: 2 month(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 10/05/2022
Initial Date OCFS Notified: 10/05/2022

Presenting Information

The SCR report alleged that on 10/4/22, the mother fed the subject child and placed her in bed with the mother and father. The mother checked on the subject child at 1:45AM and found that she was not breathing. The mother immediately called 911 and was instructed to do chest compressions. The subject child was transported to the hospital where she was pronounced deceased at 2:58AM on 10/5/22. The mother and father had a bassinet for the subject child.

Executive Summary

This fatality report concerns the death of the 2-month-old female subject child that occurred on 10/5/22. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and father. At the time of her death, the subject child resided with her mother, father, and three siblings, ages 8, 5, and 3. The father of the 8-year-old sibling resided in a separate residence.

Onondaga County Department of Children and Family Services (OCDCFS) completed collateral and casework contacts and learned that on 10/4/22, the mother fed the subject child around 10:00PM and went to sleep in her adult-sized bed on her side, with the subject child in her left arm. The mother awoke around 1:45AM on 10/5/22, noticed the subject child was unresponsive and called 911. The mother attempted cardiopulmonary resuscitation efforts at the directive of 911 dispatch until emergency services arrived. The subject child was transported to the hospital, where she was pronounced deceased at 2:58AM.

An autopsy was performed, and OCDCFS obtained the final autopsy report prior to closing their investigation. The official manner of death was listed as undetermined, and the official cause was noted to be unknown, with extrinsic and intrinsic factors that made asphyxia death likely. Extrinsic factors included bedsharing in an adult bed with the mother, and intrinsic factors included premature birth at 30 weeks gestation with bronchopulmonary dysplasia and postmortem testing positive for Sars CoV-2 and rhinovirus/enterovirus with early interstitial pneumonia.

Bereavement services were offered on behalf of the family. The 8-year-old sibling was receiving non-therapeutic counseling through school, but his father would not allow him to participate in family counseling regarding the death of the subject child. The mother and father of the subject child were not engaged in counseling, as they did not want the 8-year-old sibling to feel left out. The Risk Assessment Profile did not reflect the mother and father's mental health and therefore was inaccurately scored. The case record did not reflect that OCDCFS interviewed the father specific to the circumstances surrounding the subject child's death. There was concern regarding supervision of the 8-year-old sibling; however, there was no documentation that this was further explored with the mother. The allegations were substantiated against the mother and father due to OCDCFS determining that there was a fair preponderance of evidence to state the mother and father put the subject child at risk by placing her in an unsafe sleeping environment. The siblings were assessed to be safe in the care of the parents. The case was indicated and closed on 1/24/23.

PIP Requirement
This review resulted in a citation related to casework practice. In response, OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDCFS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDCFS 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:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **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?** Unable to determine - insufficient documentation.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
OCDCFS made an appropriate decision to substantiate the allegations based on evidence obtained throughout the investigation; however, the record did not reflect that the father was interviewed regarding the circumstances surrounding the subject child's death.

Was the decision to close the case appropriate? Yes

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:
Casework was not commensurate with case circumstances. The Risk Assessment Profile did not reflect the mother and father's MH diagnoses. The father was interviewed regarding questions related to risk assessment; however, was not interviewed about key questions relating to the circumstances of the fatality.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The Risk Assessment Profile did not reflect the parents' mental health, despite the case record noting that both parents had mental health diagnoses and were prescribed medication. The SF was engaged in mental health services prior to the fatality.
Legal Reference:	18 NYCRR 432.2(d)

Action:	OCDCFS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	While the record did reflect that the SF was interviewed face-to-face regarding risk assessment questions, there was no documentation that the SF was interviewed about circumstances surrounding the fatality.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	OCDCFS will make 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:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	OCDCFS was made aware of a concern that the 8yo SS was walking to the store unsupervised; however, the record did not reflect that this concern was further explored or addressed with the SM.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	OCDCFS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/05/2022 **Time of Death:** 02:58 AM

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: 01:51 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested 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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Other Adult - Father of 8yo SS	No Role	Male	31 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDCFS coordinated their investigation with law enforcement, spoke with collateral sources, completed a CPS history check, and conducted a home visit.

OCDCFS interviewed the SM and learned that on 10/4/22, the SM fed the SC for the last time around 10:00PM and went to sleep with the SC in her left arm. The SM reported she was lying on her side facing the wall, and the SC was on her right side facing the SM. There was a comforter on the bed, but the SM stated it was not pulled up near the SC. The SM awoke around 1:45AM on 10/5/22 and noticed the SC was limp. The SM tried to wake the SC; however, observed that the SC was not breathing and called 911. The SM reported the SC was in the same position as when they had gone to sleep but that the SM had woken up to roll over when she noticed the SC was unresponsive. The SM reported the SF was in bed and sleeping on the other side of the SM at the time of the incident and aware that the SM was co-sleeping with the SC. EMS responded to the home and attempted life-saving measures but were unsuccessful, and the SC was later pronounced deceased at the hospital.

During a home visit, OCDCFS observed safe sleep provisions for the SC, including a bassinet; however, the bassinet had baby clothes and supplies in it at the time. The SM reported that she regularly co-slept with the SC, as the SC would not sleep for long durations of time unless she was held. The SM and SF confirmed they were aware of safe sleep guidelines prior to the fatality.

OCDCFS learned during their investigation that the SC was born at 30 weeks gestation and remained in the Neonatal Intensive Care Unit until her discharge on 9/19/22. The SC needed oxygen and a feeding tube after birth. The SM reported the SC had experienced apnea during feedings and was last seen by her pediatrician on 10/4/22 for a well-child visit and to address the SC's reflux. The SC also received immunizations on 10/4/22 without any noted reactions. The pediatrician confirmed that the SM was advised to add rice cereal to the SC’s bottle starting on 10/4/22 to address the reflux. The SC had previously been prescribed medication for reflux and was last given a dose on 10/3/22.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Unknown
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 referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Onondaga County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062916 - Deceased Child, Female, 2 Mons	062917 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
062916 - Deceased Child, Female, 2 Mons	062917 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
062916 - Deceased Child, Female, 2 Mons	062918 - Father, Male, 29 Year(s)	DOA / Fatality	Substantiated
062916 - Deceased Child, Female, 2 Mons	062918 - Father, Male, 29 Year(s)	Inadequate Guardianship	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:
The record did not reflect that OCDCFS interviewed the father specific to the circumstances surrounding the fatality.

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?	☐	☐	☐	☒

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:
OCDCFS offered services in response to the fatality; however, the mother and father would not engage in services due to the father of the 8yo SS refusing to allow the SS to participate.

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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:
OCDCFS offered bereavement and MH services to the mother, father, and SSs following the subject child's death. OCDCFS provided burial assistance to 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? Yes
Explain:
Bereavement services were offered on behalf of the SSs. The father of the 8yo SS refused to allow the SS to engage in MH counseling, despite the SM feeling counseling would be beneficial to the CHN. The 8yo SS was engaged in non-therapeutic counseling through his school.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the mother and father in response to the fatality; however, the mother stated she did

not engage the family in counseling as she did not want the 8yo SS to feel left out since his father was not in agreement with his participation in services. The father of the SC was engaged in MH services prior to the fatality.

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? Yes

Infants Under One Year Old

During pregnancy, mother:

☒ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs
☐ Used prescription drugs
☐ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none of the issues listed noted in case record

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 is no known 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