Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-22-056

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

Issue Date: May 25, 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: 3 month(s)
Jurisdiction: Jefferson
Gender: Female
Date of Death: 12/22/2022
Initial Date OCFS Notified: 12/23/2022

Presenting Information

On 12/12/22, the mother and the father co-slept with the 3-month-old subject child. They both got up and left the child in their bed with a Boppy pillow and other pillows around her. The father left for work, and sometime later, the mother left the home, leaving the subject child unattended. Upon the mother's return, approximately five minutes later, she found the subject child unresponsive on the bed and bleeding from her nose. 911 was called and emergency medical services responded and performed cardiopulmonary resuscitation. The subject child was transported to the hospital where she had been on life support until 12/22/22. The child was pronounced dead at 8:34PM. The siblings (7 and 12-years-old) had unknown roles.

Executive Summary

This report concerns the death of the 3-month-old subject child. Jefferson County Department of Social Services (JCDSS) received an SCR report regarding the child's death on 12/23/22, which was subsequent to an SCR report received 12/12/22 regarding the incident that precipitated the child's death. At the time of the child's death, she resided with her mother, father, and two siblings: ages 7 and 12. The mother had a 17-year-old child who resided with the maternal grandparents and had frequent contact with the surviving siblings and subject child.

On the morning of 12/12/22, the mother and subject child woke up around 6:30AM and the mother breastfed the child. Around 7:00AM, the 7-year-old sibling came into the parents' bedroom and told her mother she needed to be at the bus stop by 7:07AM. The mother placed the subject child on her back, on the bed, with a Boppy pillow underneath her, elevating her slightly, and proceeded to wait with the 7-year-old outside on the driveway for the school bus. The mother was outside approximately five minutes before returning to check on the subject child. The mother noticed the subject child had moved and was higher up on the Boppy pillow, so that the pillow was now under the child's lower back, causing her back to arch, and her face was on the side of the pillow. The mother was unable to wake the child and when she picked her up, the mother heard a gurgling sound and saw foam and blood coming from the child's nose. The mother attempted CPR but did not know how to effectively perform it and called to the 12-year-old sibling to call 911. Law enforcement responded, and since the ambulance was still far out, transported the mother and subject child to meet the ambulance en route. Emergency medical technicians took over life-saving efforts and the child was transported to the hospital and transferred to a second hospital for further care, where she was placed on life support. The child's prognosis was grave, and care was withdrawn on 12/22/22 and the child was pronounced deceased at 8:34PM.

The death was referred to the medical examiner, who performed an autopsy of the child. The cause of death was Sudden Unexplained Death in Infancy (with extrinsic and intrinsic factors). The manner of death was undetermined. The medical examiner expanded that the extrinsic factors included an unsafe sleep environment. The intrinsic factors included congenital preaxial polydactyly, ventricular septal defect, and recent respiratory syncytial virus infection.

Law enforcement investigated. The mother was unwilling to participate in a reenactment; however, law enforcement simulated the events based on the mother's description with the Boppy pillow collected from the scene and a doll. Law enforcement said they could see how the trauma occurred with the child's head hyperextended back. Law enforcement said having just been fed, it would be easy for the child to aspirate in that position. No charges were filed, and law enforcement closed their case.

Due to the location of the subject child at the hospital, Onondaga County Department of Children and Family Services

(OCDCFS) assisted JCDSS with interviewing the parents regarding the fatal incident. JCDSS interviewed the surviving siblings and the siblings were assessed to be safe and remained in the care of their respective caregivers.

At the time this fatality report was written the CPS investigations into the fatal event and subsequent death remained open.

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?** N/A
- **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?** 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?** N/A

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 remained open at the time this fatality report was written.

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: 12/22/2022 **Time of Death:** 08:34 AM

Date of fatal incident, if different than date of death: 12/12/2022

Child Fatality Report

Time of fatal incident, if different than time of death: 07:07 AM

County where fatality incident occurred: Jefferson
Was 911 or local emergency number called? Yes
Time of Call: 07:22 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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Other Household 1	Other Adult - Father to 12yo and 7yo	No Role	Male	39 Year(s)

LDSS Response

On 12/23/22, JCDSS received a report regarding the death of the SC. An investigation into the fatal event was already underway as JCDSS had received an SCR report regarding the incident that led to the fatality on 12/12/22. JCDSS informed the DA of the fatality. The safety of the surviving siblings was assessed at the onset and upon receipt of the subsequent SCR report. A safety plan was made that the siblings would stay with the maternal grandparents until further information was known about the fatal event. The plan was appropriately lifted as relevant information was gathered to assess the siblings' safety.

OCDCFS interviewed the parents regarding the events leading up to the fatal incident. On 12/11/22, the family attended a holiday party and when they returned home, they had dinner, the father changed the SC's diaper, then the parents watched TV the rest of the night. The mother said she and the SC fell asleep earlier than the father. The SC then woke around 2:30AM to eat and went back to sleep. The SC routinely slept in the parents' bed, between the parents, placed on a Boppy pillow. The mother expressed she knew they should not use the Boppy pillow, and that the SC should not sleep in bed with them; however, it was difficult to get the SC to sleep anywhere else. The parents had a bassinet for the SC and a crib that had not yet been put together. The morning of 12/12/22, the SC and mother woke up at 6:30AM. The mother changed the SC's diaper and nursed her. The father left the house for work around 6:45AM and at 7:00AM, the 7yo SS came into the parents' bedroom to tell the mother she had to get to the school bus stop at 7:07AM. Typically, the 12yo SS rides the bus with the 7yo; however, the 12yo stayed home sick from school that morning. The mother placed the SC on her back in the

bed, with the Boppy pillow elevating her. The Boppy pillow was placed near the head of the bed with pillows behind it. The mother went out to the driveway with the 7yo and was outside approximately 5 minutes. When the mother returned and checked on the SC, the SC had scootched herself up, so that the Boppy pillow was near her lower back, and her back was arched with her face to the side. The mother went to move her, and she felt floppy. The mother tapped the SC's back and face to rouse her, but she was not responding. The mother picked the SC up, heard a gurgling sound, and observed blood and foam coming from the SC's nose. The mother set the SC on the bed and attempted CPR. The mother yelled for the 12yo SS and instructed her to call 911, which she did. Law enforcement responded quickly as they were already in the area and assisted with CPR. Law enforcement had the mother get in the back of the police car with the SC and continue CPR as they rode to meet the ambulance. The 12yo called her grandmother to pick her up, which the grandmother did.

JCDSS interviewed all siblings, none of whom had any additional information to add regarding the fatal event. The siblings did not express any safety-related concerns to JCDSS. Additionally, the grandparents expressed no concerns to JCDSS about the parents' care of the SC and the siblings.

JCDSS maintained frequent contact with the SC's treatment team. Hospital staff expressed that the mother's account of finding the SC changed three times. The blood coming from the SC's nose was a symptom of asphyxia. It was reported that the injury could have been prevented by following safe sleep protocol. Staff reported there was no evidence of trauma and they believed this was an isolated incident; however, neglect led to positional asphyxiation. The SC remained on life support from 12/12/22 until her death on 12/22/22.

Following the death of the SC, the parents and grandparents ceased communication with JCDSS. Multiple attempts were made to re-engage the family; however, they were unresponsive. JCDSS assessed the 7 and 12yo at school and mailed bereavement resources to the family.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical 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 referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063453 - Deceased Child, Female, 3 Mons	063454 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Pending
063453 - Deceased Child, Female, 3 Mons	063454 - Mother, Female, 36 Year(s)	Lack of Supervision	Pending
063453 - Deceased Child, Female, 3 Mons	063454 - Mother, Female, 36 Year(s)	DOA / Fatality	Pending
063453 - Deceased Child, Female, 3 Mons	063455 - Father, Male, 29 Year(s)	DOA / Fatality	Pending
063453 - Deceased Child, Female, 3	063455 - Father, Male, 29 Year(s)	Inadequate	Pending

Mons		Guardianship	

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:

Medical records were received and reviewed, including pediatric, cardiology, orthopedic, and audiology, although content was not documented in notes. The siblings' father was provided notice and the record reflected he was incarcerated.

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:
The family was not cooperative with further JCDSS intervention following the death of the subject child. JCDSS provided the family with community-based grief and mental health counseling services, as well as checked with the siblings' school to assess their adjustment following their sister's death.

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	☐	☐	☐	☐	☐	☒	☐

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? Unable to Determine
Explain:
Although the parent's were not receptive to JCDSS's outreaches for services, JCDSS did reach out to the siblings' schools which had connected the siblings to supports within the school. Information on community-based service providers was mailed to the parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
Following the death of the subject child, the parents did not make themselves available to JCDSS. JCDSS offered bereavement and grief counseling services to the family; however, the family was not receptive to multiple outreaches. Information on community-based service providers was mailed to the family.

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
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/12/2022	Deceased Child, Female, 3 Months	Mother, Female, 36 Years	Inadequate Guardianship	Pending	No
	Deceased Child, Female, 3 Months	Mother, Female, 36 Years	Lack of Supervision	Pending	

Report Summary:
The SCR report alleged that on 12/12/22, at 7:07AM, the mother left the subject child unsupervised for five minutes. The child was left on a Boppy pillow, which was placed on the bed. Next to the Boppy pillow, on both sides, were additional pillows. The child was in an unsafe sleep environment and as a result, the child went into cardiac arrest and was unresponsive and without oxygen for 35 minutes. The child required breathing intervention and her long-term prognosis was detrimental. The role of the father and siblings was unknown.

Report Determination: Undetermined

OCFS Review Results:
JCDSS initiated their investigation timely, contacted the source of the report, interviewed the parents and children, and maintained contact with relevant collaterals. The subject child died during the open investigation and the fatality investigation ran concurrently. JCDSS gathered relevant information surrounding the fatal incident.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

In 2019, JCDSS unsubstantiated allegations of Inadequate Guardianship and Lack of Supervision against the mother and father regarding the 7 and 12yo siblings. Allegations of Inadequate Guardianship and Parent's Drug Alcohol Misuse were substantiated against the siblings' biological father.

In 2017, Oswego County Department of Social Services (OCDSS) unsubstantiated allegations of Inadequate Guardianship, Lack of Supervision, and Parent's Drug Alcohol Misuse against the mother and father regarding the father's daughter, who resided in a separate household.

In 2016, OCDSS unsubstantiated allegations of Inadequate Guardianship, Inadequate Food/Clothing/Shelter, and Parent's Drug Alcohol Misuse against the mother regarding the surviving siblings.

In 2016, the mother participated in a FAR case, precipitated by allegations of Inadequate Guardianship and Parent's Drug Alcohol Misuse.

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