Child Fatality Report

Report Identification Number: SY-20-005

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

Issue Date: Jul 09, 2020

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	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Tompkins
Gender: Female
Date of Death: 02/07/2020
Initial Date OCFS Notified: 02/07/2020

Presenting Information

An SCR report alleged on 2/7/2020 sometime before 2:30 AM, the 2- month-old child passed away while in the care of the mother. The child was an otherwise healthy child and there was no explanation for her death.

Executive Summary

This fatality report concerns the death of the two-month-old female subject child that occurred on 2/7/2020. A report was made to the SCR on the same day regarding concerns the child passed away unexpectedly while in the care of her mother. The child died during an open CPS investigation that began on 1/9/2020 concerning unexplained bruises on the child. The mother and child were residing in a hotel at the time of the child's death. There were no siblings, or other children residing with the mother and child. The child did not have contact with her father. The father was contacted and had no information regarding the death.

Tompkins County Department of Social Services (TCDSS) coordinated investigative efforts with law enforcement upon receipt of the report. The criminal investigation was ruled an accident and no criminal charges were filed. An autopsy was performed, which revealed evidence of suffocation. The death was ascribed to be suffocation in an unsafe sleep environment (in car seat with pacifier held in place by a rolled blanket). The manner of death was best classified as an accident.

The mother reported placing the child in her car seat with a pacifier in her mouth. The child was wrapped in a receiving blanket, which held the pacifier in place. The mother began to move the child into her Pack 'N Play when she noticed the child was unresponsive, not breathing and limp. She attempted CPR on the child, and then went to the hotel's front desk and asked the employee to call 911. EMS responded and took over resuscitation efforts; however, efforts were discontinued, and the child was declared deceased.

TCDSS gathered information regarding the death from the mother, law enforcement, the medical examiner and the pediatrician.

TCDSS completed a thorough investigation and offered the mother an abundance of services including mental health counseling and burial assistance. The mother was also provided with a domestic violence referral as she reported a history of domestic violence. The mother was accepting of the services and planned to further engage in services in the future. Although the mother was notified of the SCR report in writing, she was not provided with written notice timely. The 30-day Fatality Report was completed untimely on 5/5/2020.

The allegations of Inadequate Guardianship and DOA/Fatality were substantiated against the mother regarding the child. TCDSS based their determination on information gathered during the investigation, including the medical examiner reporting the child would not have died if the mother had not placed the child in an unsafe sleep environment. The investigation was closed on 6/23/2020.

PIP Requirement
TCDSS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the TCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, TCDSS will review the plan and revise as needed to address ongoing concerns.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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 notes a consultation took place, but no details noted.

Explain:
The decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The record reflected the mother was provided with written notice of the SCR report on 6/15/2020, more than four months after the report was received.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	TCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adults named in the report within the first seven days following the receipt of the report.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	A 30-Day Fatality Report was not approved in Connections within 30-days of receipt of the report alleging the death of a child as a result of abuse or maltreatment. The 30-Day Fatality Report was approved on 5/5/2020.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	TCDSS must document and approve a 30-Day Fatality Report within 30 days of receipt of a report alleging the death of a child resulting from abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/07/2020 **Time of Death:** 02:30 AM (Approximate)

Time of fatal incident, if different than time of death: 02:20 AM

County where fatality incident occurred: Tompkins
Was 911 or local emergency number called? Yes
Time of Call: 02:26 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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
At time of incident supervisor was: Not impaired.

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	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

On 2/7/2020, TCDSS received the SCR report regarding the death. TCDSS immediately initiated their investigation by contacting law enforcement. Law enforcement and TCDSS had previously coordinated investigative efforts as a result of the initial SCR report that alleged bruising on the child. Within the first 24 hours of the receipt of the fatality report, TCDSS contacted the source of the report and notified the DA and medical examiner's offices of the death.

Law enforcement provided information they gathered upon learning of the child's death. Law enforcement was dispatched to the hotel where the mother and child were staying and found no evidence of foul play. Law enforcement did not believe the death was intentional or suspicious. Hotel staff was interviewed by law enforcement and provided information the child cried around 2:00 AM, and approximately 20 minutes later, the mother ran to a staff member asking them to call 911 as something was wrong with the child. The mother shook the child and hotel staff pinched her feet in effort to rouse the child. The mother said she propped the child in a car seat with a bottle, and when she moved the child from the car seat to

the Pack 'N Play, the child was limp. The mother attempted CPR prior to asking for assistance from hotel staff.

On 2/10/2020, the mother and maternal grandmother met with the caseworker. The family was offered services in response to the death, including mental health therapy and interviews with law enforcement were scheduled.

On 2/12/2020, TCDSS worked alongside law enforcement at the police barracks. The mother reported the day of the child's death was a typical day, she and the child spent time at the hotel and the child acted fine. The mother reported rocking the child in her car seat as a normal practice to soothe the child. Once asleep, the mother would move the child into the Pack 'N Play. On 2/7/2020, the mother rocked the child in the car seat and then went to move the child into the Pack 'N Play when she discovered the child was unresponsive and not breathing. The mother reported the child was swaddled with a pacifier; the pacifier was held into place with a blanket. Immediately, the mother began CPR. She attempted to dial 911 from the hotel room, but the call would not go through. She rushed to the front desk and asked for assistance. Hotel staff contacted 911 and the mother continued resuscitation efforts until first responders arrived.

EMS responded and transported the child into the ambulance where life-saving measures were performed but ultimately discontinued and the child was pronounced deceased.

Collaterals including the pediatrician and hotel staff who had frequent contact with the mother and child did not note any concerns for the mother's ability to care for the child. The pediatrician did not have any concerns for the child's health.

The mother was offered an abundance of services and made appointments regarding bereavement services. It remained unknown if the mother continued receiving services as she left Tompkins County prior to case closure.

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: Pathologist

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?No
Comments: TCDSS does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053943 - Deceased Child, Female, 2 Mons	053944 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated
053943 - Deceased Child, Female, 2 Mons	053944 - Mother, Female, 26 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:
Face-to-face contact was not made with the father.

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	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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was offered funeral assistance, mental health counseling and provided with a domestic violence advocate referral as the mother and her partner had a history of verbal and physical domestic violence.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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

Child Fatality Report

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/09/2020	Deceased Child, Female, 1 Months	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 1 Months	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Female, 1 Months	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Months	Mother's Partner, Male, 25 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:
An SCR report alleged on 1/8/20, the mother and parent substitute brought the 1-month-old subject child to the hospital due to a fever and fussiness. The child had bruising on her extremities, forearms, shoulder, calves and forehead in different stages of healing. The injuries were suspicious and there was no consistent explanation for them. Both adults were named as subjects. A duplicate report was received on the same day.

Report Determination: Indicated | **Date of Determination:** 06/23/2020

Basis for Determination:
The investigation revealed the mother and parent substitute brought the child to the hospital as she was fussy and did not have bowel movements. At the hospital, the child was observed to have multiple bruises in various stages of healing. The allegations of Inadequate Guardianship and Lacerations/Bruises/Welts were substantiated against the adults as there was no plausible explanation for the child's injuries.

OCFS Review Results:
The investigation was initiated timely and the sources of the reports were contacted. Safe sleep recommendations were discussed with the mother. The 7-day Safety Assessment was completed timely and accurately. Home visits were made, and the safety of the child was frequently assessed. TCDSS and medical staff frequently monitored the child's marks, which were not as significant as initially reported and faded overtime.

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

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

There was no CPS history more than three years prior to the death.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

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