Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-22-002

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

Issue Date: May 31, 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		
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: 8 day(s)
Jurisdiction: Tompkins
Gender: Male
Date of Death: 01/11/2022
Initial Date OCFS Notified: 01/11/2022

Presenting Information

Tompkins County Department of Social Services (TCDSS) received a report alleging that on 1/10/2022, the mother noticed the 8-day-old subject child was lethargic for most of the day. The child was fed at 10:30PM that night and put to sleep in a bassinet. Between 10:30PM and 1:30AM, the mother was co-sleeping with the subject child on the couch. At 1:30AM, the mother and aunt woke the subject child and attempted to feed him; however he would not take a bottle and was not behaving normally. The mother and aunt laid the subject child in a swing and went back to sleep. The aunt woke at 4AM to feed the subject child and noticed he was cold. The aunt took the child's temperature, and it was 94 degrees. The aunt and mother were able to get the child's temperature back to 98 degrees. The subject child had his arm clenched to his chest. The mother and aunt went back to sleep until 8AM when the aunt woke up to find the child unresponsive.

Executive Summary

At the time of the subject child's death, he and the mother resided with the maternal aunt, the maternal cousin, and the cousin's 9-year-old child. The mother had her own apartment but was staying with the aunt for support following the birth of the subject child. The 9-year-old relative was assessed to be safe in the care of the maternal cousin. Due to cognitive delays, the 9-year-old was unable to be interviewed. The mother provided the name of a prospective father; however, the father's name was not listed on the birth certificate and paternity had not yet been established. TCDSS exhausted efforts to locate and interview the alleged biological father, to no avail.

The investigation revealed that on 1/10/22, the mother fed the subject child at 10:30PM and placed him to sleep in his bassinet. The mother checked on the child around 1:30AM and the child was observed clenching an arm and twitching. The mother woke the aunt and expressed concern over the child's demeanor. The mother and aunt attempted to feed the child, but the child would not eat. The subject child relaxed and fell back asleep. The aunt woke and checked on the child again at 4:00AM. The aunt found the subject child cold to the touch and took his temperature, which was noted to be 94 degrees. The aunt swaddled the child and placed him on a warming pad. Once the child's temperature had risen within the normal range, the aunt placed the child back to sleep in his bassinet. Around 8:00AM, the aunt woke to find the child's breathing labored and his lips had turned blue. The aunt called 911 and began CPR at the direction of the 911 operator. First responders arrived and transported the child to the hospital where he was pronounced dead at 12:16PM.

TCDSS completed a joint investigation with law enforcement and no criminal charges were filed. First responders reported the child had a safe sleeping area and there were no observable concerns at the home. Law enforcement attended the autopsy and reported the death was likely the result of a medical condition as the child exhibited symptoms related to sepsis.

Medical records and the investigation revealed the mother delivered the subject child via C-section due to complications during birth. The mother became sick with a fever while in the hospital following the delivery and tested positive for Strep B. The subject child was not tested for Strep B after birth as it was protocol for the hospital that if the mother was treated appropriately, the infant did not need to be tested.

TCDSS contacted collateral sources and determined there was insufficient credible evidence to support the allegations of inadequate guardianship and DOA/Fatality against the mother and maternal aunt. The mother and aunt adhered to safe sleep guidelines and always placed the subject child to sleep on his back, with no items in the bassinet. The mother and

aunt were offered referrals for grief and mental health counseling. The mother was engaged in services at the time of this writing. It was unknown if the maternal aunt utilized services.

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

Explain:
TCDSS appropriately unsubstantiated the allegations given the facts and circumstances of the investigation. The case remained open for CPS Services to provide additional support to the mother following the fatality.

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:
Casework activity was commensurate with 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: 01/11/2022 **Time of Death:** 12:16 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Tompkins
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

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
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	Aunt/Uncle	Alleged Perpetrator	Female	54 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	8 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Other Adult - cousin	No Role	Female	29 Year(s)
Deceased Child's Household	Other Child - Cousin's daughter	No Role	Female	9 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)
Other Household 2	Other Adult - Father of the Other Child	No Role	Male	30 Year(s)

LDSS Response

TCDSS began their investigation upon receipt of the SCR report on 1/11/22. They adhered to approved protocols for a joint investigation with law enforcement and they interviewed the mother, maternal aunt, and maternal cousin. TCDSS spoke to the source of the report, law enforcement, the medical examiner's office, the DA's office, and medical staff.

At the time of the subject child's death, the mother had an open Preventive Services Case. The mother was receiving transitional services as she had signed herself out of foster care the year prior. Additionally, TCDSS provided the mother with support related to her pregnancy and parenting skills education.

During interviews with the mother, she reported the subject child exhibited labored breathing and was not eating normally

on the evening of 1/10/22. The mother found the subject child clenching his arm and twitching when she checked on him around 1:30AM on 1/11/22. The mother and aunt took turns checking on the subject child throughout the night. The mother reported she did not seek medical treatment immediately as the subject child experienced labored breathing while in the hospital and the first well-child visit was scheduled for 1/11/22. The mother planned to express her concerns to the pediatrician at that time. The mother denied co-sleeping with the subject child and reported, though she dozed off with the child occasionally, he was always placed to sleep in his bassinet for the night. The aunt corroborated the information received from the mother and reported she woke several times during the night to check on the subject child. Around 4:00AM, the aunt woke to find the child cold to the touch. She got his temperature within the normal range and placed him back to sleep in his bassinet. The record did not reflect what the room temperature was nor whether a fan or air conditioning unit was being used. The aunt woke around 8:00AM and found the subject child to be blue in color and his breathing was shallow. The aunt called 911 and performed CPR while waiting for first responders. The child was transported to the hospital where life-saving measures were ongoing for several hours. Ultimately, the subject child was pronounced dead approximately 4 hours after his arrival at the hospital.

Medical records revealed the subject child presented to the hospital in cardiac respiratory arrest. Medical personnel attributed the death to a medical condition and reported there was no trauma to the body. The child's symptoms were consistent with sepsis. Blood cultures collected at the hospital were positive for "cocci resembling strep." The final autopsy was received, and the death was classified as natural. The autopsy report ascribed the death to neonatal sepsis.

TCDSS determined and closed their investigation. Community-based services were offered to the family and the mother continued working with preventive services for additional support and education.

Official Manner and Cause of Death

Official Manner: Natural
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
Comments: TCDSS adhered to previously approved protocols for joint investigations by notifying the DA's office of the death and coordinating efforts with law enforcement.

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Tompkins County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060241 - Deceased Child, Male, 8 Days	060242 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
060241 - Deceased Child, Male, 8 Days	060242 - Mother, Female, 19 Year(s)	Lack of Medical Care	Unsubstantiated
060241 - Deceased Child, Male, 8 Days	060243 - Aunt/Uncle, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
060241 - Deceased Child, Male, 8 Days	060242 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Unsubstantiated

060241 - Deceased Child, Male, 8 Days	060243 - Aunt/Uncle, Female, 54 Year(s)	DOA / Fatality	Unsubstantiated
060241 - Deceased Child, Male, 8 Days	060243 - Aunt/Uncle, Female, 54 Year(s)	Lack of Medical Care	Unsubstantiated

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:

Relevant collateral sources were interviewed following the death. Attempts to locate and interview the alleged father of the subject child were unsuccessful. The 9-year-old child residing in the home was assessed, but unable to be interviewed.

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 mother was already engaged in preventive services at the time of the fatality and continued working with providers following the death. Community-based services related to mental health and bereavement services were offered to the other family members residing in the home.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
There was an other child residing in the home at the time of the fatality. That child was deemed safe in the care of her mother and no removal was necessary.

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
TCDSS provided services to the mother prior to and following the death of the subject child. At the time of the child's death, the mother was engaged in preventive services for support and education for expectant mothers. The mother received parenting skills classes, assistance with obtaining services, and assistance with housing. The services case remained open at the time of this writing.

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? No
Explain:
TCDSS determined there were no additional service needs for the 9-year-old child residing in the home. The child was receiving an array of services at school to address her developmental delays.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
TCDSS provided community-based referrals for mental health and grief counseling to the family and continued to provide education and support to the mother through an open Preventive Services Case.

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? 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 significant history regarding the mother as a child and naming the aunt as a perpetrator. The mother was removed from the aunt's care and placed in foster care in 2017. The mother remained in foster care until discharging herself on 9/9/20.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 10/08/2021

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☒	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐

Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent FASP prior to death was completed 74 days late.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐
Additional information, if necessary: TCDSS provided preventive services to the mother.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	TCDSS completed the FASP most recent to the fatality 74 days after the due date.
Legal Reference:	18 NYCRR428.3(f)
Action:	TCDSS will complete timely and accurate FASPs.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	More than 75% of the progress notes were completed more than a month after their event dates with the majority of notes being entered more than four months after their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Preventive Services History

A Preventive Services Case was opened on 10/8/21. The mother was 19 years old at the time the case was opened and pregnant. She did not have appropriate provisions for a newborn and had recently (April 2021) discharged herself from Foster Care. The mother requested help from DSS in June of 2021, when she learned she was two months pregnant. Multiple community-based and social service entities worked with the mother during her pregnancy to provide support and education. The mother engaged in parenting skills classes and obtained all necessary provisions for the unborn subject child. The mother utilized the maternal aunt for support and transportation. The subject child was born during the open Preventive Services Case.

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