Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-22-034

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

Issue Date: Dec 19, 2022

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Tioga
Gender: Male
Date of Death: 07/14/2022
Initial Date OCFS Notified: 07/15/2022

Presenting Information

An SCR report was received and alleged that on 7/14/22, the paternal grandmother was caring for the 3-month-old male subject child. The paternal grandmother put the child down for a nap, and when she came back approximately forty-five minutes later to check on the child, she found him unresponsive. The paternal grandmother called 911 at approximately 5:35PM, and the child was transported by ambulance to the hospital where he was pronounced dead at 9:35PM. The child was otherwise healthy and the paternal grandmother did not have an explanation for the child's death.

Executive Summary

On 7/15/22, Tioga County Department of Social Services (TCDSS) received an SCR report regarding the death of the 3-month-old male subject child. The report alleged DOA/Fatality and Inadequate Guardianship against the paternal grandmother. The child resided with his mother and father, and the paternal grandparents provided regular child care for the subject child. There were no surviving siblings or other children residing in the home.

Through a joint investigation with law enforcement it was learned that on 7/14/22, the subject child was dropped off to the paternal grandparents' home while the parents worked. The paternal grandmother fed the child throughout the day, changed his diaper and the child briefly napped. In the afternoon, the paternal grandmother was holding the child and he fell asleep in her arms. The paternal grandmother placed the child to sleep facedown on her bed. The paternal grandmother checked on the child approximately forty-five minutes later. The child was in the same position and his body was cold and limp. The paternal grandmother called 911 and then yelled out for the father, who was working in the barn with the paternal grandfather and uncle. The paternal uncle attempted cardiopulmonary resuscitation until first responders arrived. Resuscitative efforts were unsuccessful and the child was pronounced deceased at the home by the coroner.

An autopsy was performed, and the cause and manner of death were undetermined. The medical examiner reported that there was no anatomic cause of death after a complete autopsy examination. The manner and cause of death could not be established to a reasonable degree of medical certainty. The report referenced the sleeping conditions, stating that "the sleeping environment (face down on adult bed supported by pillows) raises the possibility of accidental suffocation; however this cannot be established scientifically." Law enforcement's investigation revealed no criminality related to the death. Law enforcement and TCDSS discussed that while there appeared to be no medical cause for the death, it was likely the child suffocated due to the soft surface of the bed.

TCDSS determined there was not a fair preponderance of evidence to substantiate the allegations of DOA/Fatality and Inadequate Guardianship against the paternal grandmother. TCDSS supported their determination by stating that the autopsy concluded that the death was undetermined, meaning no formal medical cause could be found for the death with 100% medical certainty, and that while the paternal grandmother did not follow safe sleep recommendations, there were no aggravated circumstances surrounding the child's death. TCDSS offered the parents information on grief counseling, mental health services and funeral assistance. The mother accepted a referral for grief counseling. The investigation was unfounded and closed on 10/16/22.

Although the medical examiner did not provide 100% medical certainty surrounding the cause of death, there were other components that were essential to consider in determining the investigation. The child was placed to sleep facedown on a queen size bed with a mattress topper on it that caused the bed to be soft. The child was discovered facedown with a

substance that appeared to be vomit next to him. Due to the aggravating factors of the unsafe condition of the bed, and the possibility that the child accidentally asphyxiated due to unsafe sleep, there was a fair preponderance of evidence to substantiate the allegations against the paternal grandmother.

PIP Requirement
TCDSS will submit a PIP to the Syracuse Regional Office within 30 days of 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?** No

Explain:
Although all other casework activity was commensurate with case circumstances, the determination was not supported by the information gathered throughout the investigation and the fatality reports were completed late in Connections on 10/16/22.

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:
There were no surviving siblings or children in the home; therefore, the completion of the safety assessment tools was not required.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Although there was a fair preponderance of evidence to substantiate the allegations against the paternal grandmother, TCDSS unsubstantiated the allegations.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:	TCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Syracuse Regional Office if further guidance is needed.
Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour fatality report was completed late in Connections on 10/16/22.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	TCDSS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in Connections for all reports containing an allegation of a child fatality.
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:	The 30-day fatality reported was completed late in Connections on 10/16/22.
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. The template for this report is available in Connections for all reports containing an allegation of a child fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/14/2022 **Time of Death:** 11:00 PM

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

County where fatality incident occurred: Tioga
Was 911 or local emergency number called? Yes
Time of Call: 05:35 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

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	Male	3 Month(s)
Deceased Child's Household	Father	No Role	Male	32 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	57 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	60 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)

LDSS Response

Upon receipt of the SCR report on 7/15/22, TCDSS initiated their investigation and coordinated efforts with law enforcement, contacted the medical examiner, interviewed the parents and necessary collaterals, completed a home visit, and offered services regarding the fatality.

TCDSS interviewed the paternal grandmother, who reported that on 7/14/22 at 10:00AM, the mother dropped the child off at her house. The mother stayed for a short time to feed the child and then left for work. The grandmother took the child out to the barn and set him in the driveway in a stroller. The child became hungry and the grandmother took him inside to feed him a bottle at 12:00PM. The grandfather and father were in the kitchen on their lunch break, and the grandmother left the child with them momentarily while she went to retrieve the mail. The grandmother did some work around the home, and the child was outside with her in his stroller. The child fell asleep for fifteen minutes before waking up crying. The grandmother brought the child inside and changed him. The grandfather and father came inside at 4:30PM and the child fell asleep in the grandmother's arms by 4:45PM. The grandmother placed the child on her bed on his stomach, stating the mother said the child goes to sleep on both his stomach and back. The grandmother initially tried to lay with the child, but he would not fall asleep, so the grandmother left the room. The grandmother went to pick the child up around 5:15PM, as she knew the mother would be there soon. The child was in the same position as she left him and his body was cold, blue, and limp. The grandmother called 911 and went to the front door to yell for the father. The family attempted CPR until first responders arrived. The child was unable to be resuscitated and was declared dead at the home.

The parents and grandmother were asked about the child's normal sleeping practices. The grandmother reported that she had previously tried to lay the child in a Pack N Play, but the child would continuously cry. The grandmother stated the child slept better in his swing. The child was beginning to do tummy time, and would wiggle off his play mat. The grandmother reported she would have never placed him on his stomach if he was not able to move. The parents reported receiving safe sleep guidance at the hospital when the child was born. The child napped in his swing, in a Boppy Pillow on the couch next to the mother, or on his play mat. The parents stated the child would nap on his stomach, but only when the mother was supervising. Overnight, the child slept in his crib on his back. The mother reported she had recently returned to work after having the child, and the paternal grandmother watched the child every Tuesday and every other Thursday. The parents reported no concern for the paternal grandmother's care of the child.

TCDSS interviewed the uncle and grandfather, who were present when the child was discovered unresponsive. The uncle reported he was alerted of the child's condition when the grandmother began to yell to him, the grandfather and father, who were working at the barn on the property. The uncle assisted with CPR per the instruction of 911 dispatch. The grandfather reported the grandmother cared for the child throughout the day, and he saw the child during his lunch break and had no concerns for him. The grandfather denied the child was injured, sick or left unsupervised for any extended period of time.

TCDSS gathered information from collaterals, including law enforcement and the child's doctor. Law enforcement reported no apparent concerns for the child while in the paternal grandparents' care. The statements provided to TCDSS were consistent with those given to law enforcement. The child's pediatrician reported the child was last seen in June 2022 for a lip tie. The child was examined and had no abnormalities.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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
Comments: TCDSS indicated that the fatality would be reviewed by their OCFS Child Fatality Review Team on 9/7/22.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062021 - Deceased Child, Male, 3 Mons	062025 - Grandparent, Female, 57 Year(s)	DOA / Fatality	Unsubstantiated
062021 - Deceased Child, Male, 3 Mons	062025 - Grandparent, Female, 57 Year(s)	Inadequate Guardianship	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:
The 24-hour and 30-day Fatality Reports were completed late on 10/16/22.

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	N/A
Was the child acutely ill during the two weeks before death?	No

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 no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no 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.

Additional Local District Comments

Tioga DSS contests the finding/citation that there was sufficient evidence to support an indication based on the fair preponderance of evidence standard. Tioga DSS does not feel there was a fair preponderance of the evidence to indicate the report.

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