Child Fatality Report

Report Identification Number: RO-23-009

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

Issue Date: Sep 13, 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 **Jurisdiction:** Chemung **Date of Death:** 05/04/2023
Age: 7 month(s) **Gender:** Female **Initial Date OCFS Notified:** 05/03/2023

Presenting Information

Multiple reports were received regarding the fatal incident and subject child's subsequent death. It was alleged that on 4/27/23, the mother put the subject child down to sleep in her Pack 'N Play, on her back. Between 10 and 30 minutes later, the mother found the child on her stomach and unresponsive. The mother performed CPR and called EMS. The child was transported to a local hospital and then airlifted to a secondary hospital. The child was admitted to the pediatric intensive care unit (PICU) on 4/28/23 at 3:16AM. After testing, the child was determined to have no brain activity and she was removed from life-support on 5/4/23 at 11:41AM. The child died of hypoxic brain injury and the mother had no explanation. Additionally, a few months ago, the father shook the child. It was unknown if the child was injured. It was also noted the child had a bruise to her forehead at the time she went into cardiac arrest.

Executive Summary

This report concerns the death of the 7-month-old subject child that occurred on 5/4/23. Chemung County Department of Social Services (CCDSS) received two SCR reports regarding the child's death, on 5/3/23 and 5/4/23. These reports were subsequent to two previous SCR reports received 4/28/23 precipitating the child's death. Additionally, CCDSS had an open preventive services case with the family, initiated on 12/28/22. At the time of the child's death, she resided with her mother. The father resided out of state; however, returned to NYS upon learning of the child's condition. The mother had two additional children, aged 9 and 6, who resided with their respective Article 6 custodians since the age of one month.

On 4/27/23, the mother and subject child were home in the morning and participated in a home visit at 1:30PM with the CCDSS preventive caseworker. Sometime after the child's 3:30PM bottle, the mother and child went to visit the mother's 6-year-old child at her guardian's residence. The subject child received another bottle during that visit and the mother and child returned home. Around 10:30PM, the mother placed the child in her Pack 'N Play for bed. The child was placed on her back, with no items in the Pack 'N Play other than a pacifier. The mother left the room to make another bottle and returned between 10:40-10:45PM. The mother found the child face down and unresponsive. The mother attempted CPR and observed snot coming out of the child's nose. The mother called her sister's paramour who lived next door for assistance and was told to call 911, which she did. The 911 dispatcher advised the mother on how to perform CPR until EMS arrived and took over. The child was transported to the hospital and then transferred to a PICU for further evaluation and care. The child was intubated for respiratory failure following cardiac arrest. Although there were times the child took spontaneous breaths, there was no clinical improvement since admittance to the PICU. The mother and father made the decision to withdraw respiratory support and the child was pronounced deceased on 5/4/23 at 11:41AM.

The medical examiner was notified and performed an autopsy. The cause and manner of death were pending when the CPS investigation closed. Law enforcement reported to CCDSS that the autopsy was unremarkable and there were no findings to show a cause of death, though the final autopsy report had not yet been received.

CCDSS interviewed the mother, father, and family members who had recent contact with the mother and child. CCDSS assessed the mother's two older children to be safe in the care of their custodians.

CCDSS unsubstantiated all allegations in the reports. CCDSS concluded that, due to the preliminary autopsy findings, the mother's consistent recollection of events prior to the incident, numerous collaterals reporting no concerns, and that the child was placed to sleep in a safe sleep environment, there was not a fair preponderance of evidence to substantiate DOA/Fatality against the mother regarding the death of the child. Through interviews, collateral contacts, and a review of

records, CCDSS was unable to gather a fair preponderance of evidence to support the additional allegations contained in the reports, and the reports were unfounded.

The mother continued to be involved in preventive services and community-based services when the CPS investigation was closed. The father was provided bereavement and grief resources; however, it was unknown if he engaged in services related to the fatality and it was believed he was no longer in the area.

PIP Requirement

For citations identified in the open services case, CCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS 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?** 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:

CCDSS assessed the surviving half-siblings at the onset of their involvement and immediately following the fatality. Both siblings were assessed to be safe with their respective custodians.

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 preventive services case remained open at the time the CPS investigation into the fatality was closed. The mother also continued to receive services from a community-based provider as they were assisting the mother with accessing counseling services.

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: 05/04/2023 **Time of Death:** 11:41 AM

Date of fatal incident, if different than date of death: 04/27/2023
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Chemung
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 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	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	34 Year(s)

LDSS Response

On 4/28/23, CCDSS received two SCR reports which said the SC was hospitalized after being found unresponsive in her Pack ‘N Play by the mother. Both reports noted bruising on the SC. An additional report was received on 5/3/23 alleging the SC had died; however, it was confirmed the SC remained on life-support at that time. A report was registered on 5/4/23 following the SC’s removal from life-support and death. The investigations into the fatal incident and the investigations into the death ran concurrently. CCDSS initiated their investigation upon receipt of the initial SCR reports. The sources of the reports were contacted, the DA was notified of the death, and prior CPS history was reviewed.

A timeline of the incident was provided by the mother. On 4/27/23, the SC woke up at 8:00AM, and the mother changed her diaper and fed her a bottle. They watched television and the SC was fed again around 10:30AM. At 1:30PM, the preventive services caseworker conducted a home visit with the mother and SC. The mother was asked about the bruise observed on the SC’s forehead. The mother reported the SC “headbutted” her while she was holding the SC. Medical

collaterals confirmed the bruise could be from anything pertaining to normal childhood injuries. Following the home visit, the mother placed the SC in her swing, and they watched television again until the SC was fed around 3:30PM. The mother and the SC then left the home and visited the home of the mother's 6yo child, at her custodian's residence. The mother reported nothing of concern occurred during that visit, the SC was provided another bottle, and they returned home. Around 10:30PM, the mother placed the SC in her Pack 'N Play. The SC was placed on her back, with no other items in the Pack 'N Play except a pacifier. When the mother returned about 15 minutes later to check on the SC, the SC was face down and unresponsive. The mother attempted CPR and snot was excreted from the SC's nose. Panicked, the mother phoned her sister's paramour, who resided next door, and he advised her to call 911, which she did. He came to the home to assist, and the mother continued CPR as instructed by the 911 dispatcher until first responders arrived. The SC was transported to the hospital. The timeline of events was corroborated by the 6yo's custodian and the paramour. The father was interviewed via telephone. He was not present for the event and expressed no concerns for the SC's care with the mother.

CCDSS maintained close collateral contact with the SC's medical team. The SC presented to the hospital via EMS in cardiac arrest and asystole with an estimated downtime of 20 minutes. The SC was transferred to a PICU for further care, where she remained intubated for respiratory failure. Life-support was withdrawn on 5/4/23 and the hospital reported the SC died of hypoxic brain injury. Neither hospital noted any obvious trauma. Nothing was found to support or negate non-accidental trauma and there was no apparent explanation for the SC's death at the time the CPS investigation closed.

A review of pediatric records showed concerns of poor attendance at scheduled appointments and poor weight gain, but no other significant medical problems. The mother said the father previously shook the SC; however, this had never been shared with providers prior to the death. The father was unresponsive to attempts to interview him regarding this allegation.

The mother was involved in community-based services prior to the preventive services and CPS investigations being opened. The community-based service focused on educating the mother on child development. The agency had been working with the mother since May 2022. The agency expressed no concerns with the mother's care of the child at the time of the fatality; however, had previously expressed apprehension over the mother's ability to live alone. The mother agreed to a preventive services case with CCDSS, which opened 12/28/22 and consisted of biweekly visits.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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
064062 - Deceased Child, Female, 7 Mons	064064 - Father, Male, 34 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
064062 - Deceased Child, Female, 7	064064 - Father, Male, 34 Year(s)	Inadequate Guardianship	Unsubstantiated

Mons			
064062 - Deceased Child, Female, 7 Mons	064063 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
064062 - Deceased Child, Female, 7 Mons	064063 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
064062 - Deceased Child, Female, 7 Mons	064063 - Mother, Female, 32 Year(s)	Internal Injuries	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 father was interviewed over the phone. He primarily resided out of state. Although he returned to NYS when the child was admitted to the hospital, the hospital was located a significant distance from CCDSS.

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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
A service need specific to the fatality was not identified. The 9-year-old sibling had never met the subject child and had limited contact with the mother. The 6-year-old sibling had met the child only recently. That sibling's custodian alerted the sibling's school to the death in the event the sibling required additional support.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The father was provided grief and bereavement resources; however, it was unknown if he engaged in services as he stopped responding to CPS's attempts to speak with him.

The mother continued to receive preventive and community-based services, which were assisting her with accessing mental health treatment.

History Prior to the Fatality

Child Information

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

The mother had a significant history with CCDSS.

7/4/13 An SCR report alleged the mother gave birth to a male child (half-sibling), and the mother and sibling's father were cognitively limited and unable to properly care for the sibling. The case was assigned FAR; however, safety concerns arose, and a new report was generated. The report alleged the mother and sibling's father were unable to care for the sibling; the mother had a seizure disorder and did not take her medication, resulting in a seizure. The father of the sibling was a sex offender and did not complete treatment. The mother yelled at the sibling for crying and was unable to mix formula without assistance. IG was substantiated and the sibling was placed with relatives. A subsequent report was received 9/19/13 and unfounded as the sibling was no longer residing with the parents and was in the custody of relatives under Article 6.

7/1/16 Allegations of IG were substantiated against the mother regarding a female 1-month-old half-sibling, as well as against that sibling's father. It was recommended at that time the mother engage in MH counseling and have her doctor evaluate if it was safe for her to care for the sibling alone given her seizure diagnosis. An FSS was opened, and the sibling was ultimately placed in Article 6 custody of a friend.

In 2014 and 2018, allegations of IF/C/S and IG were unsubstantiated against the mother as an unrelated home member.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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: 12/28/2022

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?	☒	☐	☐	☐
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: CCDSS maintained the case management role for the preventive services case.				

Required Action(s)

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

Issue:	Failure to Complete a Plan Amendment
Summary:	A plan amendment was not completed following the fatality. As there was no FASP due within 60 days of the death, it should have been recorded in a plan amendment.
Legal Reference:	18 NYCRR 428.7
Action:	CCDSS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

7/19/16 – 4/21/17 An FSS was opened with the mother, a 1-month-old half sibling, and the sibling's father.
A neglect petition was filed and the sibling was removed on 7/27/16. The case was closed when custody of the sibling was awarded to her placement resource. At case closing, the mother had not made significant progress in the stated service goals; she had missed multiple mental health appointments and failed to engage in recommended parenting classes. It was noted the mother and father lacked the knowledge and skills to effectively parent the sibling.

12/28/22 An FSS was open at the time of the fatality. The case was opened with the mother, then 3-month-old SC, and the father. The father resided out of state and was not actively involved in the case. Concerns noted were the mother's history and her cognitive capacity to care for the child. The record indicated the mother had an IQ of 65, multiple mental health diagnoses, and experienced seizures. It was learned in April 2023 the mother was missing the SC's doctor appointments, stopped attending MH treatment, and was had stopped parenting classes. It was unknown if the mother's seizure diagnosis impacted her ability to live and parent independently. Despite the mother's failure to actively follow the service plan, collateral contact revealed the SC was meeting developmental milestones at that time.

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