Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-19-040

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

Issue Date: Jan 21, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 07/21/2019
Initial Date OCFS Notified: 07/22/2019

Presenting Information

An SCR report alleged that on 7/17/19, a one-year-old male child was in the care of a daycare provider and sustained a subdural hematoma. Medical personnel were called and brought the child to the hospital. When the child was further examined, there were different stages of bleeding discovered on the brain. The daycare provider's explanation of what occurred to the child was inconsistent with the child's injuries. On 7/19/19, the child was pronounced brain dead. The child was set up for organ donation and taken off of life support and died on 7/21/19.

Executive Summary

This report concerns the death of a one-year-old male child that occurred on 7/21/19. On 7/17/19, Onondaga County Department of Social Services (OCDSS) received an initial report regarding injuries the child sustained while in the care of his daycare provider. On 7/22/19, OCDSS received a subsequent fatality report regarding the child's death. The reports contained allegations of inadequate guardianship, internal injuries, swelling/dislocation/sprains, and DOA/fatality against the daycare provider for the child.

On the morning of 7/17/19, the mother dropped the child off at the daycare provider's home before going to work. The mother received a call from the daycare provider around 4:27 PM, saying the child fell and hit his head and was unresponsive. The daycare provider then called 911, and police, EMS, and fire fighters arrived on scene. The child was healthy when the mother dropped him off that day, and the daycare provider was the only person to provide care for him in the hours leading up to the incident.

The daycare provider gave varying accounts of how the child sustained the injury. First responders were interviewed and did not feel the child's injury was consistent with daycare provider's explanation. OCDSS spoke with the neurosurgeon who performed a craniotomy on the child and the doctor said the child sustained multiple incidents of head trauma over a period of time. The doctor felt the story provided was not consistent with the injures. The child sustained a large fracture on the left side of his skull and there were no lacerations on the head which would be consistent with hitting a table. The child's nurse informed OCDSS there were fingernail marks observed on his right inner thigh.

The medical examiner completed an autopsy exam on 7/22/19; the cause and manner of death were pending at the time of this writing. The medical examiner's preliminary findings were that the child sustained a head injury consisting of a linear left occipital bone fracture with subdural hemorrhages and brain swelling; he received a craniotomy at the hospital. The child had contusions on each arm and left leg. Pending studies include toxicology, histology and neuropathy.

OCDSS gathered information from collateral contacts, first responders, law enforcement, the child's pediatrician, and the medical examiner. The child's pediatrician said he no reason to suspect the mother in regard to the child's death.

OCDSS and law enforcement's investigations remain open and there have not been any criminal charges filed at the time of this writing.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The caseworker activity was commensurate with best casework practice as outlined in the CPS manual.

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: 07/21/2019 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 07/17/2019
Time of fatal incident, if different than time of death: 04:27 PM

County where fatality incident occurred: Onondaga
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? 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
If the child was in day care at the time of the fatality, was the day care program duly licensed or registered? No

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	Male	1 Year(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	24 Year(s)
Other Household 2	Father	No Role	Male	25 Year(s)

LDSS Response

On 7/22/19, OCDSS received a subsequent report regarding the SC's death. OCDSS began their investigation immediately upon receipt of the initial report and coordinated investigative efforts with LE. The CW verified the report with the source and notified OCFS, the district attorney's office, and the medical examiner.

On 7/18/19, the CW and LE visited the hospital and observed the SC in a coma, hooked to multiple medical devices. The CW and LE spoke with the hospital social worker and an ICU doctor who said there were concerns the SC's injury may not have been accidental. The neurology team saw multiple layers of blood in the SC's brain which meant there were different stages of bleeding- some new, some not new. The CW then met with the BM who said she met the DCP through an internet advertisement. The BM said she got a call from the DCP yesterday, 7/17/19, and the DCP told her the SC fell and hit his head. The BM said this had happened once or twice before, the first time being in April, shortly after he started going to the DCP. She said in April, the SC allegedly tripped on his pants and fell and bumped his head; the SC sustained a small bump but acted normal. The BM said that yesterday, the DCP called her 2 minutes after the first call and said the SC was unresponsive. The DCP then called 911 and the BM rushed to get to her home. The BM said when she arrived, she saw the SC on the floor having a seizure and then the police, ambulance, and fire fighters arrived on scene. The DCP told the BM that the SC was sitting on a small chair and fell backwards and hit his head on a coffee table. The BM said she and the DCP are the only ones to watch the SC; the DCP watches the SC while BM is at work from 8AM-5PM. She said the SC's BF has no contact with him and she did not know where the BF was; she had an order of protection against him for DV. The BM said the SC saw the pediatrician at regular intervals and she signed releases for the hospital, pediatric office, and for her prenatal records. There were multiple relatives and friends at the hospital; the CW spoke with these people as collateral contacts and no one had concerns with the BM's care of the SC.

The DCP was interviewed by the CW and LE. She gave one account, then began crying and said she did not want to get in trouble, so she would tell what really happened. The second account of what happened was not much different from the first; both stories were inconsistent with the injuries. The DCP said that on 7/17/19, she was washing dishes for a while then came into the room and saw the SC standing on a toy box and yelled "what are you doing?" This startled the SC and he fell about four feet and hit his head on the left side of a hard floor and his body immediately curled up and started seizing. The DCP was shown a picture of the fingernail marks and said she did not know how those got there.

The DCP's six-year-old child was interviewed and assessed as safe in the care of the DCP and her father. The DCP stopped providing child care and obtained other employment; the six-year-old was primarily under the supervision of her father.

The CW and LE completed a home visit at the DCP's home. She provided care for two other boys, both three years old. These children were present during this home visit. One of the boys said "hi" and the DCP alleged the other child was nonverbal. The CW and LE did not speak to these children during this visit and missed an opportunity to potentially gather information regarding DCP and the subject child. The mothers of these children were interviewed and stated they had no concerns for their children in DCP's care.

The DCP said she was on probation for three years for a DWI. The CW verified this with her probation officer, who had no concerns.

Bereavement information was provided to the mother.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: From an injury - external 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 reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052245 - Deceased Child, Male, 1 Yrs	052247 - Day Care Provider, Female, 24 Year(s)	Internal Injuries	Pending
052245 - Deceased Child, Male, 1 Yrs	052247 - Day Care Provider, Female, 24 Year(s)	DOA / Fatality	Pending
052245 - Deceased Child, Male, 1 Yrs	052247 - Day Care Provider, Female, 24 Year(s)	Inadequate Guardianship	Pending

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?	☒	☐	☐	☐

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:
Burial assistance was offered and accepted by the family. Bereavement information was provided to the family but it was unknown if they had engaged in bereavement services at the time of this writing.

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the provider comply with discipline standards?	☐	☐	☐	☒
Was a Criminal History check conducted? **Date:**	☐	☐	☐	☒
Was a check completed through the State Central Register? **Date:**	☐	☐	☒	☐

Was a check completed through the Staff Exclusion List? **Date:**	☐	☐	☒	☐

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