Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-033

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

Issue Date: Dec 04, 2020

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Tioga
Gender: Male
Date of Death: 07/19/2020
Initial Date OCFS Notified: 07/19/2020

Presenting Information

An SCR report alleged two years ago, the 3-year-old SC was diagnosed with Vanishing White Matter Syndrome. The SC fell and hit his head prior; he was wheelchair bound. The SC and his 7-year-old sibling had visitation with their father every weekend. The father was aware the SC was supposed to wear a helmet during the day but during the visitation on the weekend of his death, the SC did not wear it as the mother forgot to send it. The SC did not need to wear the helmet at night to sleep and he was last seen on 7/18/2020 around 9:15 PM and appeared fine. On 7/19/2020, the father did not hear the SC make noise at his normal time and checked on the SC. The father found the SC unresponsive with vomit next to him. He called EMS at 7:30 AM and waited outside for EMS to perform CPR. The SC was pronounced dead at home. The SC had discoloration on his jaw. A subsequent report made on 7/20/2020 alleged the SF's home was filthy and in deplorable condition causing a health risk.

Executive Summary

This fatality report concerns the death of the 3-year-old male subject child that occurred on 7/19/2020. An SCR report was made the same day regarding the child's death. A subsequent report was received the following day and consolidated into the initial SCR report. The child was known to have a medical condition, Vanishing White Matter Disorder, that he was expected to succumb to by the time he was 7 years old. The child resided with his mother and two siblings, ages 2 and 7 years. At the time of his death, the child was visiting his father's home with his 7-year-old sibling and 15-year-old cousin who spent a significant amount of time at the father's home. The father had a 11-month-old child who resided with his mother who often visited the father's home. The children were assessed to be safe. The father had other minor children who did not visit him or have a relationship with the subject child. The father resided with his mother, who was not home at the time of the incident.

Tioga County Department of Social Services (TCDSS) coordinated investigative efforts with law enforcement immediately upon learning of the death. Law enforcement stated their investigation did not reveal any probable cause for criminal charges. An autopsy was performed, and the cause of death was Sudden Death Associated with Vanishing White Matter Disorder and the manner was natural.

The father explained the children were visiting him for the weekend and that the child acted normally on the day prior to his death. The father slept in the bed with the children but moved to a recliner during the night. In the morning, he found the child unresponsive and not breathing. He carried the child outside, performed CPR and contacted 911. When first responders arrived, rigor mortis had set in and resuscitation efforts were discontinued. The child was pronounced deceased at the home. Additionally, the mother and paternal grandmother did not have details regarding the death as they were not present at the time of the incident.

TCDSS interviewed multiple collateral contacts including the sources of the reports, first responders, the parents, several healthcare providers and family members. There were no concerns for the care either of the parents provided to the child.

TCDSS made several home visits and assessed the safety of the children who resided with or had frequent contact with the child. They were assessed to be safe in the care of their parents and caregivers. Although the children were assessed, the record did not reflect the parents of the cousin were interviewed regarding the SCR report. Additionally, the record did not reflect the father of the 2-year-old sibling was interviewed.

After gathering sufficient information to determine the allegations within the report, TCDSS unsubstantiated all allegations against the parents and grandmother. The record reflected the child died as a result of his pre-existing medical condition and his death was not a result of any action or inaction by the caregivers. The investigation revealed the child did not have to wear a helmet at all times. Additionally, the discoloration on the child's face was confirmed to be a result of his disorder. Furthermore, the home was assessed to meet minimal standards for the children. TCDSS closed the case after completing all Safety Assessments and required reports timely and accurately.

PIP Requirement

TCDSS and Tompkins County will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the local district has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, local district 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:**
  - **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

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:

The record did not reflect the paternal uncle, mother to the cousin or the father to the 2-year-old sibling were interviewed regarding the SCR report.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Child Fatality Report

Summary:	Although the parents of the subject child and 7-year-old sibling, and mother of the 11-month-old sibling were interviewed, the record did not reflect the parents of the cousin or father of the 2-year-old sibling were interviewed.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	TCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/19/2020 **Time of Death:** Unknown

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: 07:30 AM
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 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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	44 Year(s)

Other Household 1	Grandparent	Alleged Perpetrator	Female	60 Year(s)
Other Household 1	Other Adult - Mother of the 11-month-old sibling	No Role	Female	36
Other Household 1	Other Child - Cousin	No Role	Female	15 Year(s)
Other Household 1	Sibling	No Role	Male	11 Month(s)
Other Household 2	Other Adult - Father to youngest sibling	No Role	Male	33 Year(s)
Other Household 3	Other Adult - Paternal Uncle	No Role	Male	42 Year(s)
Other Household 4	Other Adult - Mother to Cousin	No Role	Female	41 Year(s)

LDSS Response

TCDSS immediately initiated their investigation alongside law enforcement after learning of the death. Within the first 24 hours of the death, a home visit was made, the safety of the children was assessed, and the parents were interviewed. A CPS history check was documented, the sources of the reports were contacted, and the district attorney's office was notified of the death.

On 7/19/2020, a home visit was made with law enforcement. Law enforcement provided information that the father said a few months ago the child fell from his wheelchair and hit his head; the child's doctor expected the child to begin having seizures; however, the father had not witnessed the child seize. On the night of the fatal incident, the father picked up the child and the 7-year-old sibling from the mother around 5:00 PM. They went to the home and the father fed the children dinner; the child acted normally. Law enforcement said the father slept on the floor next to the bed while the children slept on the bed. The grandmother was not home when the father discovered the child unresponsive in the bed.

The father was interviewed together with the paternal grandmother at their home. The father said the child was able to walk and talk normally until he fell and struck his head on a doorknob. The child was diagnosed with Vanishing White Matter Disorder and was expected to live no longer than 5 years. The father said the child's condition caused his brain to detach from the brainstem. The paternal aunt was present during the interview and noted she saw the child the night prior to the fatal incident and observed the child to be happy and fine.

On 7/20/2020, TCDSS spoke with the mother of the 11-month-old sibling and assessed him to be safe in her care.

A home visit was made on 7/20/2020 to assess the safety of the 7-year-old sibling. The sibling said he, the father and the child had shared a bed, but he was not positive where the father slept the night of the fatal incident. The sibling said he did not hear the child in the night. When he woke up, the father and the child were no longer in the room and he saw the child was in an ambulance. He was told to go to a family member's home who lived on the property. He had no additional information.

Law enforcement noted the ME said there was no trauma to the child and the autopsy showed the child's gray matter was void in spots. Law enforcement's investigation did not reveal criminality in response to the death.

On 7/21/2020, the 11-month-old sibling was assessed to be safe in the care of his mother. On 7/22/2020, the 2-year-old sibling was observed to be safe in the care of her mother. On 7/23/2020, the 15-year-old cousin was assessed to be safe with her caregivers. She did not have information regarding the death.

Information gathered from the coroner stated the child had a life expectancy of 7 years. The pathologist noted the autopsy findings were very typical of an individual with the child's disorder. The child's neurologist said the child was assessed on 7/14/2020 and observed the child's condition to have worsened; however, the child did not appear gravely ill. The neurologist planned to evaluate the child for seizures. Information was gathered that the child would not have to wear a

helmet constantly as he was non-ambulatory. Furthermore, the child's neurologist stated it was not surprising that the child died suddenly due to his disorder.

The family was offered an abundance of services including mental health and bereavement services. Some of the services were accepted by the family. The Risk Assessment Profile did not identify a need for further involvement from TCDSS and the case was appropriately determined and closed timely.

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

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
055450 - Deceased Child, Male, 3 Yrs	055454 - Father, Male, 44 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055454 - Father, Male, 44 Year(s)	DOA / Fatality	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055454 - Father, Male, 44 Year(s)	Inadequate Guardianship	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055454 - Father, Male, 44 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055454 - Father, Male, 44 Year(s)	Lack of Medical Care	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055453 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055453 - Mother, Female, 29 Year(s)	Lack of Medical Care	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055456 - Grandparent, Female, 60 Year(s)	DOA / Fatality	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055456 - Grandparent, Female, 60 Year(s)	Inadequate Guardianship	Unsubstantiated
055450 - Deceased Child, Male, 3 Yrs	055456 - Grandparent, Female, 60 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
055451 - Sibling, Male, 7 Year(s)	055454 - Father, Male, 44 Year(s)	Inadequate Guardianship	Unsubstantiated
055451 - Sibling, Male, 7 Year(s)	055454 - Father, Male, 44 Year(s)	Inadequate Food / Clothing / Shelter	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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The family was offered an abundance of services in response to the death. The father was accepting of the services while the mother was undecided if she was ready to engage in counseling. The children were offered appropriate services.

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? Yes
Explain:
The cousin and 7-year-old sibling were offered services in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The adults were offered bereavement, mental health and addiction services counseling in response to the fatality.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/10/2020	Sibling, Female, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 1 Years	Mother, Female, 29 Years	Lack of Supervision	Far-Closed	

Report Summary:
An SCR report received by Tompkins County alleged the mother failed to adequately supervise the 14-month-old sibling. On 1/10/2020, the 14-month-old sibling ran away from the mother while she was on her phone. The sibling ran down the street before the mother caught her. When the mother caught her, she grabbed the sibling by the hood of her coat, kicked her and took her into the home. The sibling got out of the house and ran 20 feet down the street before the mother noticed she was gone. The mother grabbed the sibling by the hood again, lifting her 2 feet off the ground. The mother carried her like this into the home. As a result, the sibling was choked by the coat.

OCFS Review Results:
The investigation was appropriately tracked FAR, initiated timely and the source was contacted. A CPS history check was documented timely. The FLAG was completed with the mother. The record did not reflect attempts to gather information from the children or note diligent attempts to contact the father. Notice of FAR letters were provided timely and notices of FAR closure were provided. The 7-day Safety Assessment was completely timely and accurately.

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

Issue:
FAR-Failure to Engage the Family

Summary:
The record did not reflect diligent attempts were made to interview the father regarding the allegations. Additionally, the record did not reflect attempts were made to gather information from the children.

Legal Reference:
18 NYCRR 432.13 (e)(2)(iii)

Action:
Family assessment response workers must work in partnership with the families participating in a family assessment response. Workers should be transparent with families regarding all actions that they take regarding the case. To the extent feasible, child protective service workers should include all family members in discussions, including children who are old enough to express opinions.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/23/2018	Sibling, Male, 5 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother's Partner, Male, 31 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother's Partner, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother's Partner, Male, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 42 Years	Other	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 42 Years	Other	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received by Tompkins County alleged the SC had a handprint bruise on his face. The explanation given

for the injury was inconsistent with the injury. On 9/17/18, the SM changed the 5-year-old SS's clothes outside next to her car. When she angrily yanked off the SS's clothes, his legs got caught and he fell. The SS hit his head against the wheel of the car. It was unknown if he was injured. A subsequent report received on 10/25/2018 alleged the SM and father to the youngest sibling abused drugs while caring for the CHN. The father of the youngest child left bruises on the SC. It was unknown if the older SS was physically harmed.

Report Determination: Unfounded | **Date of Determination:** 11/28/2018

Basis for Determination:
Tompkins County added the allegations of XOTH against the father regarding both children due to a COI. The allegation of PD/AM was added against the mother and parent substitute regarding both children. Tompkins County unfounded the investigation as there was no evidence the adults used drugs or caused harm to the children. The bruise on the child's face was believed to be from the sibling.

OCFS Review Results:
The investigation was initiated timely, a CPS history check was documented, and the source was contacted. Written notice of the SCR report was provided timely to the adults. Although seen face-to-face, the record did not reflect full interviews with children and adults listed on the report. The record did not reflect safe sleep information was provided. The 7-day Safety Assessment was completed untimely.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
Although completed accurately, the 7-day Safety Assessment was completed untimely on 10/3/18.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
Tompkins County will complete all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

Issue:
Failure to provide safe sleep education/information
Summary:
The record did not reflect the parents were provided with safe sleep recommendations and guidelines with regard to the 3-month-old sibling. Additionally, the sleeping areas of the children were not documented to have been observed.
Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:
Tompkins County will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
Although present during a home visit, the record did not include a conversation with the father regarding the SCR report despite being a subject of the report. Additionally, the record did not reflect information collected from the parents regarding overall safety and risk of the children including supervision, discipline and domestic violence.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
Although the children were seen, and an attempt was made to interview the sibling on 9/25/18, the record did not reflect further attempts to interview the sibling or attempts to interview the child.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

[redacted]

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

4/20/10- 6/3/10- The father was UnSub for IG of other CHN.

4/20/10 - 7/1/10- The father was UnSub for IG of other CHN.

6/02/11- 7/29/11- The parents of the cousin were UnSub for IG, L/B/W of the cousin and other CHN.

1/18/11 -3/17/11- The grandmother was UnSub for IG of other CHN.

1/24/11- 4/28/11- The father was Unsub for IG of other CHN.

2/9/12- 4/6/12- The grandmother was Sub for IG and L/B/W of other CHN.

8/23/13- 9/19/13 The paternal uncle and another adult were UnSub for IG, L/B/W, PD/AM, CD/A of the cousin and other CHN.

10/31/13- 12/30/13- The parental uncle and another adult were UnSub for PD/AM, CD/A, LS, IG and SXAB regarding the cousin and other CHN.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No