NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-15-039 **Prepared by: Buffalo Regional Office**

Issue Date: 4/15/2016

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
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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 8 day(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 10/04/2015
Initial Date OCFS Notified: 11/18/2015

Presenting Information

On 10/04/2015 at Woman's and Children's Hospital of Buffalo, the child passed away in the Neonatal Intensive Care Unit. The exact cause of death is still unknown to DSS. A release of information needs to be signed by mother to allow DSS to speak to the hospital around the cause of death and obtain medical records. DSS will attempt to have a release of information signed. There was no SCR report made after child passed away and it is suspected the death is related to the child's premature birth. An SCR report was received 09/28/2015 prior to the child's death related to the mother testing positive for marijuana at the time of the infant's premature birth. There are no surviving siblings. The twenty year old mother resides with her parents and siblings. The only minor child within the home is a sixteen year old.

Executive Summary

This report involved a subject child in an open SCR report investigation that passed away during the course of the investigation. The open report involved allegations of Parent’s Drug/Alcohol Misuse against subject mother stemming from her positive toxicology for marijuana during birth of subject child. Subject child did not test positive for marijuana or other drugs, but was born at twenty-five weeks and began treatment for complications resulting from his premature birth. Subject child subsequently died eight days after birth while still in the hospital and receiving treatment.

Subject mother resided in her parent’s home just before subject child’s birth with plans for her parents to help her temporarily. No safety concerns were found in the home or reported by case or collateral contacts. There was one sixteen year old surviving child in the home.

Subject mother had an extensive JD behavioral history with two placements in Gateway-Longview Residential care. Her criminal records include arrests for impersonation related to prostitution, assault against her mother, harassment, and contempt of Court. Subject mother also has a history of substance abuse and treatment.

Subject mother acknowledged marijuana use during her pregnancy with reported plans to discontinue use in her last trimester. She denied any heavy alcohol use during the pregnancy. After subject child was born prematurely, subject mother also reported plans to discontinue her marijuana use with plans to breast feed subject child.

Erie County DSS notified Buffalo OCFS of subject child’s death in an open report on 11/18/2015. The delay in notification was the result of a lapse in Caseworker activity which resulted in the Caseworker not being aware of subject child’s death until forty-nine days after he had died. A Required Action was made in this review regarding this lapse in caseworker activity. There was no SCR Fatality report received regarding the subject child's death. There was no criminal investigation or charges.
Medical providers reported subject mother had not participated in pre-natal care. Medical records documented subject child’s extensive medical complications stemming from his premature birth. No medical records indicated subject mother’s marijuana use as a cause for subject child’s medical needs. The hospital pathologist completed the final autopsy report and subject child’s Certificate of Death listed the cause of death as cardiopulmonary arrest as a consequence of hemorrhage due to the prematurity of his birth.

On 12/7/2015, the allegations of Parent's Drug/Alcohol Misuse against subject mother were UNFOUNDED. Basis of findings: Subject mother did test positive for marijuana at the birth of subject child. Subject child was born at twenty-five weeks. Subject child did not test positive for marijuana. Subject child passed away eight days after birth due to complications resulting from the premature birth. Shortly after subject child's death, Subject mother moved to Florida. Counseling services were offered to home members and declined. Case is closed with no further CPS intervention required. Sixteen year old surviving child in home appears safe.

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:
N/A Explained above.

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 was a lapse in casework activity that resulted in the Caseworker not being aware the subject child had died until forty-nine days after he had died. Regular casework contacts must be maintained to provide for on-going assessment of risk and safety concerns in all open SCR abuse/neglect reports.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Child Protective Services casework contacts
Summary:	There was a lapse in casework activity resulting in the Caseworker not being aware the subject child had passed until 49 days after SC died. SC child died 8 days after birth while being treated for complications resulting from his premature birth.
Legal Reference:	432.2(b)(4)(vi)
Action:	Regular case and collateral contacts must be maintained to provide adequate on-going assessment of

	case risks and safety concerns.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/04/2015 **Time of Death:** 05:58 PM

County where fatality incident occurred: ERIE
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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: At hospital being treated for complications relate

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	21 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	8 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	50 Year(s)
Deceased Child's Household	Mother	No Role	Female	20 Year(s)
Deceased Child's Household	Other Child	No Role	Female	16 Year(s)

LDSS Response

On 09/28/2015 Erie County Child Protective Services received an SCR report with allegations of Parent's Drug/Alcohol

Misuse against subject mother stemming from her positive toxicology for marijuana during birth of subject child. Subject child did not test positive for marijuana or other drugs, but was born at twenty-five weeks and began treatment for complication resulting from his premature birth. Subject child subsequently died eight days after birth while still in the hospital and receiving treatment.

The Caseworker initiated the investigation making case and collateral contacts. Ample food was observed in the home, medical information was obtained, background checks were conducted for subject mother and other adults in the home, SCR history was gathered and assessed, and school contact was made regarding the surviving child. No safety concerns were found in the home or reported by collateral contacts.

Medical providers reported subject mother had not participated in pre-natal care and obtained medical records discussed subject child's extensive medical complications stemming from his premature birth. No medical records indicated subject mother's marijuana use as a cause for subject child's medical needs.

Subject mother had an extensive JD behavioral history with two placements in Gateway-Longview Residential care 7/12/11 – 6/22/12 and 3/16/10 – 12/23/10. Her criminal records include arrests for impersonation related to prostitution, assault against her mother, harassment, and contempt of Court. No other member of the household had a criminal history. Subject mother also has a history of substance abuse and treatment.

Subject mother resided in her parent's home just before subject child's birth with plans for her parents to help her temporarily. Shortly after the death of subject child, subject mother moved to Florida with her boyfriend to reportedly reside with her boyfriend's family. Subject mother's parents reported kicking subject mother out of the home due to her unwillingness to work or help with bills.

Subject mother acknowledged marijuana use during her pregnancy with reported plans to discontinue use in her last trimester. She denied any heavy alcohol use during the pregnancy. After subject child was born prematurely, subject mother also reported plans to discontinue her marijuana use with plans to breast feed subject child.

Subject child passed away eight days after birth while remaining hospitalized since birth for treatment of complications related to his being born at twenty-five weeks. Erie County DSS notified Buffalo OCFS of subject child's death in an open report on 11/18/2015. The delay in notification was the result of a lapse in Caseworker activity which resulted in the Caseworker not being aware of subject child's death until forty-nine days after he had died. There was no SCR Fatality report received in relation to the subject child's death. There was no criminal investigation or charges.

The hospital pathologist completed the final autopsy report and subject child's Certificate of Death listed the cause of death as cardiopulmonary arrest as a consequence of hemorrhage due to the prematurity of his birth.

On 12/7/2015, the allegations of Parent's Drug/Alcohol Misuse against subject mother were UNFOUNDED. Basis of findings: Subject mother did test positive for marijuana at the birth of subject child. Subject child was born at twenty-five weeks. Subject child did not test positive for marijuana. Subject child passed away eight days after birth due to complications resulting from the premature birth. Subject mother has moved to Florida. Counseling services were offered to home members and declined. Case is closed with no further CPS intervention required. Sixteen year old surviving child in home appears safe.

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: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Erie County does not have an OCFS approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
Most case notes were timely with a few exceptions. Subject child passed away while in the hospital since birth being treated for complications related to his premature birth. There was no criminal investigation. Child only lived for eight days.

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 safety 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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: No children were removed as a result of this fatality investigation.				

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	Needed but not Offered	Needed but Unavaliable	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:
Bereavement counseling was offered to all household members and declined.

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:
The Caseworker offered grief counseling to the sixteen year old surviving cousin child in the home. She declined counseling reporting no bond to the child as he had died shortly after birth and contact was very limited.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The Caseworker offered grief counseling to subject mother and the other adults in the home. This service was declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	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?	Yes

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 within three years prior to the fatality.

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

Subject mother has no CPS history as a perpetrator other than the open SCR report of 9/28/2015 pertaining to subject child's premature birth with subject mother testing positive for marijuana use at the time of subject child's birth. Subject child was not positive for marijuana or any other tested drugs. Subject child only lived eight days and also has no prior CPS history other than this report at the time of his birth.

SCR report 9/28/2015 Allegations of Parent's Drug/Alcohol misuse. UNFOUNDED 12/07/2015. Basis: Subject mother did test positive for marijuana at the birth. Subject child was born at twenty-five weeks. Subject child did not test positive for marijuana. Subject child passed away eight days later due to complications regarding the premature birth. Services offered and declined. Subject mother moved to Florida and is residing with boyfriend and his family.

Known CPS History Outside of NYS

There is no known CPS history outside New York State for this family.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

We find that the facts describe the unfortunate event with respect to this infant passing away due to natural causes and being born premature. We acknowledge that in the report dated September 28, 2015 we did not fulfill the need to make regular contacts with the family for whom we have an open investigation. While a casework contact would not have

prevented this unfortunate event, we are acutely aware of the need to make regular case and collateral contacts throughout the entire investigation and have already taken corrective measures. Specifically, a memo was distributed to all investigative staff by The CPS Administrative Director, on March 7, 2016. The memo reminded staff about the protocol for the frequency of contacts with children and families Involved in a CPS Investigation. As OCFS is undoubtedly aware, caseload management is paramount in our minds, superseded in importance only by safety and risk management and family strengthening. We appreciate the opportunity to partner with OCFS in providing the best possible services to families in our community.

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