NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-16-030 **Prepared by: Spring Valley Regional Office**

Issue Date: 1/25/2017

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	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Still Born
Age: Unknown
Jurisdiction: Westchester
Gender: Unknown
Date of Death: Unknown
Initial Date OCFS Notified: 07/17/2016

Presenting Information

A report was received by the New York Statewide Central Register of Child Abuse and Maltreatment on 7/17/2016 listing allegations of DOA/Fatality, Fractures, Lack of Medical Care and Inadequate Guardianship regarding the mother and father on behalf of the stillborn infant. This report alleged a 911 call was initiated as the mother was in labor at her house in the bathtub. A second call was made indicating the mother had given birth but the stillborn infant was not breathing. CPR instructions were provided to the father by the 911 operator. The stillborn infant was in cardiac arrest when EMS arrived and still attached to the umbilical cord. The report alleged the stillborn infant also had sustained a compressed skull fracture from inappropriate birthing techniques by the parents. The parents were interfering with the EMS providing medical attention and the delay interfered with the stillborn infant's chance of survival. The stillborn infant was pronounced dead at the hospital.

Executive Summary

The investigation revealed that during the early morning hours of 7/17/2016, the mother began to experience contractions, which she believed to have been Braxton Hicks contractions, and sat in a warm bath to relieve the pain. The mother did not realize she was actually in labor and as was preparing to exit the bathtub, she felt spontaneous urges to push and she delivered the stillborn infant in the bath tub. The mother reported the stillborn infant was born in the amniotic sac which she described as being greenish in color. The mother broke the sac, noted a foul smell, and discovered that the stillborn infant was not breathing. The father contacted 911 and the operator provided instructions on how to preform CPR on the stillborn infant. When EMS arrived, the paramedics cut the umbilical cord which the mother described as being flat and lacking color, and the stillborn infant was taken via ambulance to the hospital. As per the EMS patient care report, the stillborn infant appeared “gray, ashen, meconium stained, had a severe depression on the back of the skull and the skin appeared to have been peeling off.” Resuscitative efforts continued en route to the hospital where they continued until the stillborn infant was pronounced dead by an emergency room physician at 4:25 AM. As per the mother and father, the birth was not planned as a home birth.

An autopsy was performed on the stillborn infant. As per the Medical Examiner, there was no evidence to support this was a live birth. Hospital staff indicated that the stillborn infant was likely dead for “some time” as the skin was “peeling off.” Local law enforcement officials explained that there appeared to be no wrong doing. The cause of death was determined to be intrauterine fetal demise due to placenta abruption and infection in placental membranes. As it was determined that the child died in utero, accordingly the Office of the District Attorney closed their investigation. The parents have no other children and there were no minor children residing in the home.

All of the allegations listed on the report were unsubstantiated regarding the mother and father as the labor occurred spontaneously and there was no live birth. Appropriate service referrals were offered to the mother and father. At the time of case closure, the mother and father were working with a Victims Assistance Services, engaged in bereavement counseling, and casework counseling. Burial assistance was also offered to the family. The CPS investigation was closed on 9/15/2016.

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:
All the assessments and the investigation determination were appropriate.

Was the decision to close the case appropriate? Yes

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 decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Male	30 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim		
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

Westchester County Department of Social Services, (WCDSS), conducted an investigation into the allegations listed on the report. WCDSS made appropriate collateral contacts including the local law enforcement officials, hospital staff, the

Medical Examiner, relatives, and community resources. All subjects were interviewed and observed, and the allegations were discussed. Appropriate service referrals were offered to the family.

The mother and father had no other children and there were no minor children residing in the home. WCDSS completed all safety assessments and the risk assessment profile (RAP) accordingly. The case notes were well documented, detailed and contemporaneous.

As per the patient care report from the ambulance company, there were no signs of life from the time EMS arrived. Medical records received from the hospital indicated the stillborn infant was pronounced dead at 4:25 AM, by an emergency room physician, following continuous failed resuscitative efforts by the family, EMS and hospital personnel. No indication of any trauma or other injury indicative of abuse or neglect was noted at the hospital. The mother had received limited prenatal care and was refusing various testing at the hospital. She ultimately consented to treatment and there was also a psychiatric consultation. It was determined the mother did not require Psychiatric follow-up upon her discharge. Although the specific gestational age was not clearly established, based on the mother's account about learning of the pregnancy around 11/24/15, the gestational age would have been at least eight months.

Local law enforcement officials explained that there appeared to have been no wrongdoing, and the subject child appeared to have been a stillborn. During their investigation, local law enforcement officials also determined the incident to have been “unintentional,” in that the birth was not expected to occur at this time. CPR instructions were provide by the 911 operator over the phone and the family did allow EMS to proceed with medical intervention for the stillborn infant. As a result, no charges were pressed against the mother or father.

There was documentation of supervisory conferences noted in which the circumstances of the case were discussed and directives were provided.

The CPS investigation was closed on 9/15/2016 and the allegations on the report were determined to have been unsubstantiated regarding the mother and father on behalf of the stillborn infant for Inadequate Guardianship, Lack of Medical Care, Fractures and DOA/Fatality. Appropriate service referrals were provided to the family for bereavement services and aid with funeral expenses.

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The fatality investigation was conducted by an MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The case was reviewed by an OCFS approved Child Fatality Review Team on 8/1/2016.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
031384 - Deceased Child, ,	031385 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
031384 - Deceased Child, ,	031386 - Father, Male, 35 Year(s)	Lack of Medical Care	Unsubstantiated

031384 - Deceased Child, ,	031386 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
031384 - Deceased Child, ,	031385 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
031384 - Deceased Child, ,	031385 - Mother, Female, 22 Year(s)	Lack of Medical Care	Unsubstantiated
031384 - Deceased Child, ,	031385 - Mother, Female, 22 Year(s)	Fractures	Unsubstantiated
031384 - Deceased Child, ,	031386 - Father, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
031384 - Deceased Child, ,	031386 - Father, Male, 35 Year(s)	Fractures	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:

Attempts were made by the department to contact the source on 7/19, 7/21, and 7/25. The source did not return the phone calls.

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	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:
The family was engaged in bereavement counseling services and working with a Victims Assistance Services (VAS) worker at the time of case closure.

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? N/A
Explain:
There were no surviving siblings or other children residing in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement counseling services and burial assistance were offered to the family. The family was receptive to services.

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 known CPS history on file for the family.

Known CPS History Outside of NYS

There is no known CPS history on file for the family outside of New York State.

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.

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

No additional local district comments noted.

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