Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-018

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

Issue Date: Aug 20, 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 day(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 05/04/2020
Initial Date OCFS Notified: 05/06/2020

Presenting Information

On 5/5/20, Onondaga County Department of Social Services learned of the death of the 3-day-old subject child. At the time of the fatality, there was an open child protective investigation. On 5/5/20, Onondaga County Department of Social Services notified the Syracuse Regional Office via the 7065-Agency Reporting Form.

Executive Summary

This fatality report concerns the death of a 3-day-old female subject child that occurred on 5/4/20. At the time of the fatality, Onondaga County Child Protective Services (OCDSS) had an open investigation with the family with concerns regarding the mother's drug use while pregnant and the premature birth of the subject child. OCDSS learned of the death on 5/5/20 and reported it to the Office of Children and Family Services (OCFS) via the 7065-Agency Reporting Form on the same day.

OCDSS met with the mother following the fatality. A brief interview was conducted and the mother reported the death of the subject child was her fourth fetal demise and she had no other living children. OCDSS offered the mother grief counseling services, which she reported she intended to enroll in. The mother identified the father of the subject child, and he was not contacted during the investigation. There was no contact made with the subject child prior to her death.

OCDSS utilized collateral contacts to gather information related to the fatality of the subject child. It was learned the child had been delivered by an emergency caesarean section while the mother was at the hospital for unrelated medical matters. The child was born with significant medical concerns and transferred to another hospital to receive additional care. At the hospital, life saving efforts were made, including surgery to place a drain due to free air in the child's abdomen. Despite those efforts, the subject child remained critically ill and succumbed to her medical conditions.

An autopsy was performed and the final results were not yet available at the time the fatality report was written. The preliminary results provided diagnoses of small for gestational age, perforation of transverse colon, clinical history of three prior fetal demises and maternal hemolytic anemia, elevated liver enzymes and low platelet count syndrome (HELLP) and placenta size (less than tenth percentile). Law enforcement was not contacted regarding the fatality; therefore, a criminal investigation was not conducted.

During casework and collateral contacts, OCDSS missed opportunities to gather information related to the fatality of the subject child and the three prior fetal demises. Medical records obtained by OCDSS notated a history of substance abuse by the mother; however, there was lack of follow up with medical personnel to determine if the mother's substance abuse contributed to the subject child's death and three prior fetal demises. OCDSS documented the receipt of the mother's medical records and subsequently summarized the records by correlating the mother's drug use and her fetal demises. This was an inaccurate representation of the medical records, which were also reviewed by OCFS. Additional information would have assisted OCDSS in determining if an SCR report should have been made regarding the subject child's death and possibly the deaths of the three prior children.

During the investigation, OCDSS offered the mother grief counseling; however, there were other service needs identified where a referral for additional services would have been appropriate.

PIP Requirement

This review resulted in a citation related to casework practice. In response, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

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?** No, sufficient information was not gathered to determine any of the allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
The mother was not interviewed by OCDSS related to the open CPS investigation and there was insufficient information gathered related to the fatality.

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:
OCDSS failed to interview the mother regarding the allegations, despite having had the opportunity to do so. There was insufficient information gathered related to the allegation and the death of the subject child. There were no surviving siblings and OCDSS determined there was no need for further CPS involvement.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/04/2020 **Time of Death:** 12:45 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? No
Did EMS 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

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	Aunt/Uncle	No Role	Female	56 Year(s)
Deceased Child's Household	Deceased Child	No Role	Female	3 Day(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)

LDSS Response

OCDSS had an open CPS investigation with the family at the time of the child fatality. The SCR report was received on 5/1/20, with concerns regarding the mother's substance abuse while pregnant and the premature birth of the subject child. OCDSS learned of the subject child's death on 5/5/20 and notified the Syracuse Regional Office via the OCFS-7065 Agency Reporting Form on the same day.

OCDSS gathered information regarding the fatality from collateral contacts. The subject child was born via an emergency C-section after the mother was admitted to the hospital for unrelated medical reasons. The child was born at 27-weeks gestation with significant medical concerns and admitted to the neonatal intensive care unit. After further evaluation the child was transferred to another hospital for additional treatment. Despite extensive supportive care, the child was pronounced deceased on 5/4/20 at 12:45AM with the mother present. The preliminary causes of death provided by the attending physician were prematurity, spontaneous bowel perforation, apparent cardiac arrest and apparent respiratory arrest. The mother consented to an autopsy and the final results were not yet available at the time OCDSS closed their case.

OCDSS met with the mother at the hospital after the death of the subject child. The mother reported she has had 3 prior fetal demises. The mother did not receive pre-natal care while pregnant with the subject child. During this casework contact, the mother was offered grief counseling, which she reported she intended to enroll in. OCDSS did not interview the mother related to the CPS investigation and there was no further contact made with the mother.

The aunt was interviewed via telephone related to the allegations against the mother. The aunt reported significant substance abuse by the mother during her pregnancy, in addition to concerns regarding the mother's mental health and history of homelessness.

OCDSS indicated the allegation of PD/AM against the mother and closed their investigation on 5/27/20.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The mother was offered grief counseling and it was unknown if she utilized this service. During the investigation the mother was referred to substance abuse treatment by the hospital.

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 siblings or other children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was offered grief counseling.

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? N/A
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/01/2020	Deceased Child, Female, 1 Days	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes

Report Summary:
An SCR report alleged that on 5/1/20, the mother gave birth to a baby girl. The mother's toxicology was positive for marijuana at the time of delivery. The role of the aunt was unknown.

Report Determination: Indicated **Date of Determination:** 05/27/2020

Basis for Determination:
Onondaga County indicated the allegation of Parent Drug/Alcohol Misuse against the mother related to the subject child because the mother tested positive for marijuana at the time of the subject child's birth and admitted to substance use during the pregnancy.

OCFS Review Results:
OCDSS conducted a timely investigation and completed all notes contemporaneously. There is no documentation that the source of the report was contacted. While there is documentation of face to face contact with the mother, it did not consist of an interview with the mother or questions related to the allegations. The father of the subject child was identified by the mother and he was not added to the investigation, interviewed or notified of the report. There was not enough information gathered to support the indication.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There was no documentation that OCDSS contacted the source of the SCR report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
OCDSS will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify adequacy of report and possibly glean additional information. (or, including) OCDSS will document the contact or attempts at contact.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
OCDSS failed to complete pertinent casework tasks, including an interview with the mother related to the allegations and the death of her child. In addition, the father of the SC was not contacted and there was insufficient information gathered from collaterals to support the determination. The mother reported this was her 4th fetal demise and there was no discussion regarding family planning.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
OCDSS will review and adhere to regulations regarding FAR practice and casework practice in general. OCDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Issue:
Appropriateness of allegation determination
Summary:
OCDSS supported the indication of PDRG against the MO by stating that the MO used drugs while pregnant and that this was the MO's 4th fetal demise because of drug misuse. Drug use by the MO and a positive drug test is not enough information to support the indication. The documentation did not show negative impact to the SC or state the SC's death was a result of the MO's drug use.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, will take into consideration all information when applying the circumstances to the definition(s) and will consult with the Syracuse Regional Office if technical assistance is required.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
OCDSS made face to face contact with the mother; however, failed to complete an interview with her related to the allegation or any other safety and risk factors. The father of the child was not interviewed.
Legal Reference:
432.1 (o)
Action:
OCDSS will complete interviews with the alleged subjects of the investigation,which may include but are not limited to, facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Failure to provide notice of report
Summary:
The mother provided the name of the subject child's father and OCDSS failed to notify him of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Issue:

Adequacy of Progress Notes

Summary:

OCDSS documented that they received medical records related to the death of the SC and those records were made available to OCFS upon request. OCDSS summarized those records incorrectly, by correlating the death of the child to the mother's substance abuse. The medical records reported a history of substance abuse by the mother; however, do not state it resulted in the death of the SC.

Legal Reference:

18 NYCRR 428.5

Action:

OCDSS will accurately document all casework activity into progress notes.

[redacted]

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

The mother had one investigation in 2011 with unfounded allegations of Sexual Abuse regarding an unrelated child.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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

Action:	OCDSS may benefit from following the Non-SCR reported fatality check list provided by the CPS Program Manual in Chapter 14 section L-5. While this is not a requirement by OCFS, it is a tool that can be utilized to ensure there is sufficient information gathered related to the fatality and that appropriate action is taken by OCDSS with any information obtained.

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