Child Fatality Report

Report Identification Number: SY-22-039

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

Issue Date: Jan 23, 2023

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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 4 day(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 08/12/2022
Initial Date OCFS Notified: 08/12/2022

Presenting Information

Onondaga County Department of Children and Family Services (OCDCFS) completed an OCFS-7065 Agency Reporting Form on 8/12/22, after learning of the 4-day-old female subject child's death.

Executive Summary

On 8/12/22, OCDCFS was notified by the hospital that the subject child passed away on the same date having never left the hospital. OCDCFS had an open CPS investigation at the time, which was initiated on 8/9/22, the day after the subject child was born. The CPS report alleged there was not an appropriate caregiver for the subject child as the mother had significant substance abuse history, unstable housing, and no provisions for the subject child. The father of the subject child was incarcerated at the time of the SCR report for reasons unrelated to the fatality.

The subject child was born via cesarean section at 30 weeks gestation and had multiple diagnoses, including prematurity. The mother had a clinical history of active IV heroin abuse and opioid dependency at the time of birth. The mother received no prenatal care until she presented to the hospital in June 2022. The mother was admitted to the hospital in June but signed out against medical advice. She was readmitted to the hospital in July, where she remained until giving birth to the subject child. The child remained in the NICU, receiving oxygen and required antibiotics.

OCDCFS investigated the circumstances surrounding the subject child’s death and they learned that on 8/11/22, the subject child’s condition worsened. An abdominal x-ray showed dilated loops in the right abdomen. The child received IV fluids and ventilatory settings were increased. Despite maximum medical intervention, the child continued to decline. The subject child succumbed to her medical condition at 3:55AM on 8/12/22.

An autopsy was completed and listed the cause of death as septic shock in the setting of prematurity. Due to the conditions surrounding the death, law enforcement was not involved.

The investigation open at the time of the fatality was unfounded and closed on 12/13/22. The mother was referred for mental health counseling, bereavement services, and substance abuse treatment. Bereavement resources were provided to the father, who remained incarcerated at the time the investigation was closed. The parents had no other children in their care.

PIP Requirement
For citations identified in historical cases, OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS 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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The death of the subject child was not reported to the SCR, therefore, safety assessments and a determination were not required.

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

Explain:
Based on the information OCDCFS gathered, they determined there was no reasonable cause to suspect the death was a result of abuse or maltreatment. The investigation open at the time of the death was closed once all case objectives were met.

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: 08/12/2022 **Time of Death:** 03:55 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: hospitalized		

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	No Role	Female	4 Day(s)
Deceased Child's Household	Mother	No Role	Female	29 Year(s)
Other Household 1	Father	No Role	Male	29 Year(s)

LDSS Response

On 8/12/22, OCDCFS was notified by hospital staff that the subject child passed away on the same date. Upon being notified of the subject child's death, OCDCFS notified the Syracuse Regional Office and submitted the required 7065 Agency Reporting Form. OCDCFS spoke to providers and all relevant collateral sources. There were no siblings or other children residing in the home.

Through interviews with medical personnel, it was learned the subject child was born prematurely and had multiple medical complications at birth. The child was admitted to the NICU following birth, where she received medical interventions related to her medical complications. It was learned that, despite the mother's history of substance misuse and ongoing positive toxicology results during her pregnancy, screenings were not conducted to determine prenatal drug exposure. On 8/11/22, the subject child's health rapidly declined, and life-saving interventions were performed. Ultimately, the child succumbed to medical complications and was pronounced dead.

Hospital records and the postmortem medical examination confirmed the subject child passed away due to prematurity and complications during birth and not due to abuse or maltreatment by the mother.

OCDCFS conducted interviews with the mother and learned she had a lengthy history of substance abuse. The mother had been in and out of treatment. Information was received from medical personnel that a family member brought drugs into the hospital for the mother while she was admitted following the birth of the subject child. When OCDCFS confronted the mother with that information, she dismissed the concerns stating she did not realize they were in the makeup bag that had been brought to her. The mother did not have a stable residence and reported she would be staying with her grandmother until securing a place of her own. Prior to the child's death, OCDCFS devised a safety plan with the mother as she was not a viable caregiver for the subject child due to her substance abuse, transient lifestyle, and lack of provisions for the subject child.

OCDCFS spoke with the father at the precinct where he was incarcerated. The father denied paternity had been established but reported having ongoing concerns for the mother's care of the subject child due to her substance abuse history. OCDCFS provided the father with bereavement resources.

Throughout the investigation, OCDCFS consulted with their legal department and had multiple supervisory consultations due to the mother's significant substance abuse history and failure to plan for the subject child. The investigation open at the time of the subject child's death was ultimately closed as there were no other children in the parents' care.

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 referred to an OCFS approved Child Fatality Review Team? Yes

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:
This was not an SCR reported fatality. OCDCFS spoke with relevant collateral sources and gathered information to determine the death was not the result of abuse or neglect.

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:
OCDCFS provided bereavement resources to the mother. The mother was engaged in substance abuse treatment following the death of the subject child.

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 in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Community-based fatality related services were offered to the mother.

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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☒ Used illicit drugs
- ☐ Used prescription drugs
- ☐ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With neither of the issues listed noted in case record

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)
08/09/2022	Deceased Child, Female, 1 Days	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
OCDCFS received a report from the SCR alleging the mother had a significant history of drug use including heroin, fentanyl, opiates, and cocaine. In June 2022, the mother was hospitalized and placed on IV antibiotics due to heart issues caused by her drug use. At the time, the mother signed out against medical advice and resumed consuming drugs while pregnant with the subject child. The mother returned to the hospital in July and tested positive for opiates, cocaine, and benzodiazepine. The mother was placed in drug treatment; however, failed to adhere to program recommendations. The mother gave birth to the subject child on 8/8/22, and had no provisions or plan of care for the child.

Report Determination: Unfounded | **Date of Determination:** 12/13/2022

Basis for Determination:
OCDCFS determined there was no credible evidence to support the allegation of Inadequate Guardianship against the mother regarding the subject child. Though the mother had a significant history of substance abuse, OCDCFS determined there was no impact on the subject child. The child was born premature with multiple medical complications and OCDCFS did not find evidence to support that the child's death was the result of abuse or neglect. OCDCFS did not take into consideration what was alleged in the SCR report and based their determination on the child's death being the result of medical complications and not abuse or neglect.

OCFS Review Results:
OCDCFS consulted their legal department and documented supervisory consultation throughout the investigation. Because death was not expected for the child, OCDCFS was safety planning for the subject child as the mother was not a viable resource. OCDCFS ultimately unfounded the allegation of Inadequate Guardianship despite having information to support the allegation.

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

Issue:
Appropriateness of allegation determination

Summary:
OCDCFS and their legal department determined the mother was incapable of being an adequate guardian for the subject child due to her history of substance misuse and her inability to plan for the care of the subject child. Despite this information, OCDCFS unsubstantiated Inadequate Guardianship.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
OCDCFS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult their Regional Office if further guidance is needed.

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

The mother was listed as the Parent Substitute with no role on an investigation from 1/25/2018.

Known CPS History Outside of NYS

There was no known history outside of New York State.

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