Child Fatality Report

Report Identification Number: SY-22-058

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

Issue Date: Jun 12, 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 had an open investigation or a CPS monitored services 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: 8 day(s)
Jurisdiction: Cortland
Gender: Male
Date of Death: 12/23/2022
Initial Date OCFS Notified: 12/23/2022

Presenting Information

Cortland County Department of Social Services (CCDSS) completed an OCFS-7065 Agency Reporting Form on 12/24/22, after learning of the 8-day-old male subject child's death. There was an open investigation at the time of the death due to the mother giving birth to the subject child and twin sibling, and being unable to provide adequate care for them.

Executive Summary

On 12/23/22, CCDSS was notified by hospital staff that the 8-day-old male subject child passed away on the same date. CCDSS had an open CPS investigation, which began on 12/15/22, following the birth of the subject child and twin sibling, due to concerns for the mother's ability to care for the children. At the time of his death, the subject was hospitalized. The mother was being housed as homeless in a motel by CCDSS.

CCDSS completed casework and collateral contacts and learned that on 12/15/22, the mother's water broke while in her motel room. The grandmother, who was present in the motel room, called 911; however, by the time emergency medical services arrived, the grandmother had delivered the twin sibling and was holding him in her arms. The grandmother reported that when the twin sibling was born, he was initially responsive, but became unresponsive shortly after. The twin sibling was transported to the hospital and stabilized. The mother was transported to the hospital where she then delivered the subject child. Both twins were medically fragile due to the circumstances surrounding their birth and being premature. Both twins were transported to another hospital for more advanced medical care in the Neonatal Intensive Care Unit (NICU) where they remained. On 12/21/22, the twin sibling experienced low oxygen levels, low blood pressure, decreased heart rate, and began bleeding from a severe infection and ultimately died on the same date. The subject child began exhibiting similar symptoms and died on 12/23/22 from the same infection.

An autopsy was completed, and the final cause of death for both the subject child and twin sibling was listed as Neonatal Herpes Virus Infection. The autopsy listed diagnoses as preterm male infant with herpes virus, fulminant herpes virus hepatitis with massive necrosis, bilateral adrenal cortical necrosis, and splenic necrotic foci and inflammation. The clinical notes in the autopsy stated there was herpes virus in the children's spinal fluid. Law enforcement initially responded to the births of the twins, but the record did not reflect if there was an on-going criminal investigation regarding the deaths.

The mother and grandmother were referred to grief and family counseling. The mother had a preventive case that was open prior to the birth of the twins and remained open until 4/20/23. The mother was assisted with housing, benefits, and transportation, and referred to various services for family planning, parenting classes, adult protective services, and case management. The allegations of Inadequate Guardianship in the investigation open at the time of death were substantiated due to the mother's inability to care for the children. There were no surviving siblings.

PIP Requirement
For citations identified in historical cases, CCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS 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:
This was a non-SCR reported fatality and therefore, no determination was 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:
Casework was commensurate with case circumstances.

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: 12/23/2022 **Time of Death:** Unknown

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 and/or ingested 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	Male	8 Day(s)
Deceased Child's Household	Mother	No Role	Female	19 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Day(s)

LDSS Response

On 12/23/22, CCDSS learned of the SC's death, and began gathering information regarding the circumstances surrounding the fatality.

The BM and MGM were interviewed and reported that on 12/15/22, the BM was not feeling well and began bleeding vaginally. The BM's water broke, she laid down, and the MGM called 911 at 10:43AM. Before EMS was able to respond, the MGM delivered the twin sibling in the motel room. The MGM stated the SC was delivered breech but responsive; however, became unresponsive. The twin sibling and BM were transported to the hospital and the BM gave birth to the SC. The BM remained in the hospital due to medical complications and the twins were transported to another hospital, where they remained in the NICU until their deaths.

The record reflected the BM identified the twins' BF and CCDSS was provided contact information for another possible BF; however, the record did not reflect CCDSS followed up with either individual.

CCDSS opened a preventive case with the BM on 11/30/22 to assist in preparing the BM for the birth of the CHN. The BM was cognitively delayed, homeless, and being housed with the MGM who was actively engaging in substance misuse. The day prior to the CHN's birth, the MGM overdosed and was banned from the motel she had been sharing with the BM. The MGM was not supposed to be present at the motel at the time of the CHN's birth. The MGM was the BM's only support and the BM planned to utilize the MGM as a caregiver for the CHN, despite knowledge of the MGM's current and past substance misuse.

CCDSS obtained collateral information from EMS, law enforcement, and hospital staff that provided care to the twins; however, the record did not reflect prenatal records for the BM were requested or received.

After the birth of the twins, CCDSS began family court proceedings to file an Article 10 Petition in family court against the BM and conduct a removal of the twins. The petition was withdrawn following the death of the twins' deaths, as there were no surviving CHN.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

Comments: Cortland County Department of Social Services 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?	☒	☐	☐	☐

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Community Based Services

Additional information, if necessary:
The BM was referred to grief counseling and CCDSS assisted with funeral arrangements. Although the BM's preventive and adult protective cases closed following the deaths of the twins; the BM was referred to numerous community based programs to provide additional case management services. The MGM had a services case that remained opened to address her on-going substance use.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM and MGM were referred to grief counseling following the death of the SC and twin sibling. The BM was referred to community resources to provide case management services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

- ☒ Had medical complications / infections
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs

☐ Had a positive toxicology at the time of delivery ☐ Used prescription drugs
☐ Used marijuana ☐ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ With a positive toxicology ☐ With fetal alcohol effects or syndrome
☐ Exhibiting withdrawal symptoms ☒ With none 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)
12/15/2022	Deceased Child, Male, 1 Days	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 1 Days	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The SCR report alleged the BM gave birth to twins, and was cognitively delayed, and unable to adequately care for the CHN. The BM was homeless and did not have all proper provisions to care for the CHN on her own. The MGM had an unknown role.

Report Determination: Indicated **Date of Determination:** 03/22/2023

Basis for Determination:
The BM was working with CCDSS prior to the birth of the twins. The BM was homeless and shared a motel room with the MGM, until the MGM was kicked out for overdosing on 12/14/22. The BM stated her plan for childcare of the twins was the MGM and failed to recognize the MGM was in active addiction and not engaged in services. The BM had an IQ of 65 and limited understanding of concepts and simple tasks. The BM was given reality babies but failed. The BM did not complete the required week and scored a 36% for one baby and 0% for the other. The twins died while in the NICU. Prior to their deaths, CCDSS considered an Article 10 Petition and removal due to the BM's inability to provide proper care.

OCFS Review Results:
CCDSS initiated their investigation by contacting the source of the report and completing a CPS history check. CCDSS interviewed the BM and MGM regarding the circumstances surrounding the twins' birth. CCDSS remained in contact with medical staff caring for the twins while in the NICU, and regularly obtained updates regarding their medical status until their deaths. CPS and preventive caseworkers worked together to provide services to the BM after the twins' birth and following their deaths. The record reflected the BM identified who she believed the twins' BF was and CCDSS was provided contact information for another possible father, but did not follow up with either individual.

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

Summary:
The BM identified who she believed the father of the twins was; however, the record did not reflect attempts by CCDSS to locate or interview him. CCDSS received additional information about another possible father and was provided his contact information, but there was no documentation CCDSS followed up with that individual.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
CCDSS will make 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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 11/30/2022

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☐	☒	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The initial FASP was completed on 3/6/23. No comprehensive FASP or Plan Amendment were completed prior to case closure.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Preventive services were opened and provided to the BM by CCDSS prior to the birth of the SC and twin sibling to assist with housing. The BM was receiving community-based services to prepare for the birth of the twins.				

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was not completed until 3/6/23, despite being due on 12/9/22 and the CHN being born on 12/15/22. No Plan Amendment was completed after the death of the CHN and prior to the FSS being closed on 4/20/23.
Legal Reference:	18 NYCRR428.3(f)
Action:	CCDSS will complete timely and accurate FASPs.

Preventive Services History

A voluntary preventive case was opened on 11/30/22 due to the mother being 19yo, pregnant with twins, and homeless. Services were provided by CCDSS and community agencies to assist the mother in preparation of the twin's births. Both twins died during the open preventive case, and it was closed on 4/20/22 due to there being no surviving children and the mother being referred to community resources.

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

Cortland County disagrees with the findings in this report.

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