Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-18-018

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

Issue Date: Dec 13, 2018

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		

Case Information

Report Type: Child Deceased
Age: 26 day(s)
Jurisdiction: Orleans
Gender: Female
Date of Death: 06/17/2018
Initial Date OCFS Notified: 06/21/2018

Presenting Information

On 6/17/18, a 26-day-old female child died while hospitalized at Strong Memorial Hospital. The child was listed in an open CPS investigation at the time of her death.

Executive Summary

Orleans County Department of Social Services (OCDSS) received a report from the SCR on 6/14/18 with concerns the 1-year-old surviving sibling was malnourished and had not received necessary medical care.

This fatality report concerns the death of the SC which occurred on 6/17/18. OCDSS received notification of the child's death on 6/19/18 and notified the Buffalo Regional Office on 6/20/18 with the required 7065-Agency Reporting Form noting the SC died during an open CPS investigation.

The SC died while in the Neonatal Intensive Care Unit at Strong Memorial Hospital, where she had been hospitalized since birth. The SC was born with severe birth defects that required medical intervention. On 6/17/18, the SC's condition deteriorated and she died as a result. The hospital physician determined SC's manner of death was natural and the cause of death was birth defects; therefore, no autopsy was performed.

The fathers of the children were incarcerated and attempts were not made to interview them.

OCDSS thoroughly investigated the circumstances surrounding SC's death and determined her death was not caused by abuse or maltreatment. OCDSS assessed the safety of the two surviving siblings, ages 2 and 1.

The initial case was substantiated for allegations of inadequate guardianship, lack of medical care, malnutrition/failure to thrive, and lack of supervision against the mother. A preventive services case was opened and the mother was referred to parenting skills classes, budgeting classes, WIC, mental health counseling, and Early Intervention services.

PIP Requirement
For issues identified in historical cases, OCDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issues. For issues where a PIP is currently implemented, OCDSS 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:
SC's death was not reported to the SCR, therefore no safety assessments or investigation determination were 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:
A Preventive Services case was appropriately opened.

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: 06/17/2018 **Time of Death:** 05:15 PM

County where fatality incident occurred: Monroe
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? N/A
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: Hospitalized

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	Deceased Child	No Role	Female	26 Day(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)
Other Household 2	Other Adult - BF of 2 yo SS	No Role	Male	41 Year(s)

LDSS Response

OCDSS notified OCFS of SC's passing and conducted a home visit within 24 hours of becoming aware. OCDSS spoke to BM and the home was assessed to be safe. The 1yo SS's medical needs were addressed and a required medical appointment was scheduled. BM stated SC remained hospitalized since birth due to her delays and disabilities. She received a call from hospital staff on 6/17/18, informing her that SC's condition was deteriorating. She arrived at the hospital and SC passed away in her arms. BM stated the father of the 1yo SS and SC was incarcerated and was brought to the hospital prior to SC's passing to say goodbye.

Through the open investigation it was learned SC was born on 5/22/18, and was admitted to the Neonatal Intensive Care Unit with multiple medical issues and she was not expected to survive. OCDSS thoroughly assessed the safety of the SS. The 1yo SS was malnourished and not gaining weight; the BM missed several medical appointments that were made to monitor the child's weight. OCDSS assisted the BM with following through with the recommended medical appointments and in providing the children with proper nutrition. There were also concerns for the 2yo SS's behavior and BM's ability to properly supervise the children. BM was referred to multiple services and provided with bus passes. OCDSS appropriately indicated the case and opened a Preventive Services case to provide BM with the needed services.

OCDSS thoroughly investigated the death of SC. Hospital records were received and the physician determined SC's death was due to birth defects and not caused by the actions or inactions of the BM.

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: There is no OCFS approved Child Fatality Review Team in Orleans County.

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?	☒	☐	☐	☐
Was there an adequate 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?	☐	☐	☒	☐

Explain:
The death of the SC was not reported to the SCR, therefore 24-hour and 30-day safety assessments were not required. The safety of the SS was assessed within 7 days.

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	☒	☐	☐	☐
Explain: Service needs were adequately assessed and Preventive Services were offered and accepted.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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: Preventive Services							

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BM was referred for MH counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/14/2018	Sibling, Male, 2 Years	Mother, Female, 21 Years	Lacerations / Bruises / Welts	Unsubstantiated	Yes
	Sibling, Male, 2 Years	Mother, Female, 21 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 2 Years	Mother, Female, 21 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 1 Years	Mother, Female, 21 Years	Inadequate Guardianship	Substantiated	

Sibling, Male, 1 Years	Mother, Female, 21 Years	Lack of Supervision	Substantiated
Sibling, Male, 1 Years	Mother, Female, 21 Years	Lacerations / Bruises / Welts	Substantiated
Sibling, Male, 1 Years	Mother, Female, 21 Years	Lack of Medical Care	Substantiated
Sibling, Male, 1 Years	Mother, Female, 21 Years	Malnutrition / Failure to Thrive	Substantiated

Report Summary:
An SCR report alleged, in May 2018, the 1yo SS was seen at the doctors office and at that time he only weighed 16 lbs which is the same weight that he was when he was 5 months old. BM was not giving the child formula and she was only giving him 1 cup of milk every 2-3 days for financial reasons, so the child was malnourished. Since the child's last visit, BM missed multiple doctors appointments. BM was failing to properly address the situation and the child was going without the needed medical attention. A subsequent report was received on 7/18/18 and was merged, which alleged BM failed to supervise the children and the 1yo SS had a bruised forehead and the 2yo SS had a bruised eye.

Report Determination: Indicated | **Date of Determination:** 08/20/2018

Basis for Determination:
OCDSS determined the 1yo SS was underweight and delayed in speech, OT and PT skills. BM failed to feed him properly or follow through with required medical appointments for weight checks. The child had not gained weight since he was 5 months old. The 2yo SS was delayed in speech and had behavioral issues that BM was unable to manage. The 2 yo pushed the 1yo over in his highchair, resulting in a laceration to the 1yo's forehead that required stitches. On 6/26/18, the 2yo got out of the home while BM was sleeping and had to be brought home by LE. BM was unaware the child got out or how long he had been gone.

OCFS Review Results:
OCDSS completed a thorough investigation of the allegations and made referrals for the family for community-based services and Preventive Services. The SC was born prematurely during the case and OCDSS determined SC died from natural causes from birth defects. Though notified, no effort was made to interview the 2yo SS's BF or BF of the 1yo SS and SC, who were both in jail. The case was appropriately opened for Preventive Services.

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:
Both BFs were added to the report as parents and notified about the investigation, though there was no effort to interview them.

Legal Reference:
432.1 (o)

Action:
OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/14/2017	Sibling, Male, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes

Sibling, Male, 1 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 1 Years	Mother, Female, 19 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 1 Years	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 1 Years	Mother, Female, 19 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 1 Years	Mother, Female, 19 Years	Lack of Supervision	Unsubstantiated

Report Summary:
An SCR report alleged BM and her unknown paramour were leaving the 1yo SS unsupervised. SS had been found wandering the hallways in the apartment complex while BM and her paramour were sleeping. The family resided on the third floor of the complex. SS did not appear to have sustained injuries; however, SS was filthy, he wore the same clothes for days at a time, and smelled of urine and cigarettes. There was no food in the home and SS was missing meals regularly and going hungry. A subsequent report was received on 4/18/17 and merged, with allegations SS had suspicious bruises and scratch marks on his body and a rash on his leg.

Report Determination: Unfounded | **Date of Determination:** 05/09/2017

Basis for Determination:
The "unknown paramour" was identified to be BF. OCDSS determined the parents appeared to have been providing SS with a minimal degree of care: Ample food was always found in the home, SS's clothing appeared to be changed on a daily basis, collaterals had not seen SS wandering the halls and the apartment door was said to have always been locked. SS had minor scratches, a rash and a bruise that did not appear inflicted and cleared up during the investigation.

OCFS Review Results:
OCDSS completed a thorough investigation of the allegations and made referrals for the family for community-based services. OCDSS discussed safe sleep with SM upon the birth of 1yo SS, which occurred during the open case, and provided her with a portable crib; however, there was no documented safe sleep discussion with BF. Though notified, no effort was made to interview the 2yo SS's BF, who was in jail.

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 2yo SS's BF was added to the report as a parent and notified about the investigation, though there was no effort to interview him.

Legal Reference:
432.1 (o)

Action:
OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/30/2016	Sibling, Male, 7 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes

Sibling, Male, 7 Months	Mother, Female, 19 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 7 Months	Mother, Female, 19 Years	Lack of Medical Care	Unsubstantiated
Sibling, Male, 7 Months	Mother, Female, 19 Years	Swelling / Dislocations / Sprains	Unsubstantiated

Report Summary:
An SCR report alleged the 2yo SS (7-months-old at the time) presented with 2 bruises on the forehead; 1 was relatively small, the other was substantial with swelling. The explanation for the injuries was not plausible and was considered suspicious. On that date, the SS was vomiting and there was concern he may have head trauma. The BM was aware but refused to bring the child to the doctor.

Report Determination: Unfounded | **Date of Determination:** 05/25/2016

Basis for Determination:
OCDSS unsubstantiated the allegations due to a lack of credible evidence. OCDSS observed the bruises on the SS's head and noted SM's explanation (that in 2 separate instances he toppled over and hit his head on a wall) which was determined to be consistent with what was observed.

OCFS Review Results:
OCDSS made efforts to identify the SS's BF in order to notify him, and learned paternity had not been established. OCDSS referred BM to community-based services, information of which BM appeared receptive. OCDSS made appropriate collateral contacts, commensurate with case circumstances. Safe sleep was discussed on 4/26/16, although SM may have benefited from a discussion about safe sleep sooner, as there were blankets observed in the portable crib at the initial home visit on 3/30/16.

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

Issue:
Review of CPS History

Summary:
It was documented that a review of CPS history was not completed until the eighth day of the investigation.

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

Action:
Within five business days of report, OCDSS will review and document a CPS history review, including all CPS record(s) that apply to the prior reports where the current report involves a subject of the report, a child named in the report or a child's sibling named in the report.

[redacted]

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

There is no CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS 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

Additional Local District Comments

Adequacy of face to face contacts: May 2018

One parent is incarcerated in federal prison in Mississippi. Another is incarcerated in another county in New York. Though in person interview was not possible for parent out of state telephone contact could possibly have been attempted. A courtesy secondary visit could have been requested for the parent incarcerated in NYS.
Staff has been re-educated on the importance of face to face contact with parent/guardian when possible.

Adequacy of face to face contacts: May 2017
Parent is incarcerated. If able every effort must be made to have parent interviewed in person, minimally by telephone.
Staff has been re-educated about the importance of face to face contact with parent/guardian.

Review of CPS History: May 2016
Importance of history while in beginning stages of investigation was discussed with staff as well as the reference that within 5 business days OCDSS will review and document CPS history.

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