Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-22-016

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

Issue Date: Nov 01, 2022

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: 13 day(s)
Jurisdiction: Steuben
Gender: Female
Date of Death: 05/23/2022
Initial Date OCFS Notified: 05/24/2022

Presenting Information

Steuben County Department of Social Services (SCDSS) completed an OCFS-7065 Agency Reporting Form on 5/24/22, after learning of the 13-day-old female subject child's death. A NICU doctor reported the mother was not at fault for the infant's condition and indicated a delay in medical care due to the remote location in which the family lived, and a transportation decision made by EMS contributed to the subject child's critical condition. EMS arrived one hour after the birth and the SC was later airlifted; formal medical care began around hour two after birth.

Executive Summary

On 5/23/22, SCDSS was informed of the subject child passing away on the same day due to complications following her birth on 5/10/22. There was an open CPS investigation at the time of the fatality that had been reported to the SCR on the same day as the subject child's birth, with concern regarding the mother's ability to care for a newborn child. At the time of her birth, the subject child's mother resided with an ex-boyfriend who will be referred to as an unrelated home member. The alleged father of the subject child resided in Florida, and paternity had not been established. There were no other surviving siblings or children in the home.

SCDSS learned that on 5/10/22, the mother felt uncomfortable and went into the bathtub where she then gave birth to the subject child. The mother informed the unrelated home member of the subject child's birth and he went to a neighbor's residence; the neighbor called EMS. Upon arrival, EMS attempted to clear the subject child's airway, as she was having difficulty breathing. The subject child was transported by EMS to a landing location where she was then airlifted to the hospital. The subject child remained in the hospital until the time of her death.

The subject child was born at 28 weeks gestation. No autopsy was performed, but medical staff reported the subject child's death was related to necrotizing enterocolitis, direct hyperbilirubinemia, acute hemorrhagic infarction of the brain, adrenal insufficiency, anasarca, ineffective thermoregulation, disseminated intravascular coagulation, acute kidney injury, patent ductus arteriosus, elevated liver function, thrombocytopenia, pulmonary hemorrhage, respiratory failure, respiratory distress syndrome, anemia, hypotension, and lactic acidosis. The official manner and cause of death were declared as natural causes from cardio respiratory arrest, refractory hypotension, multiorgan failure, and complications of prematurity.

For the duration of the subject child's hospitalization, the mother disregarded the severity of the subject child's condition. She would not discuss next steps with the hospital to make medical decisions for the subject child. This resulted in hospital staff discussing the case with their ethics legal team.

When the subject child was in distress, the mother could not be reached for five days, and when hospital staff or SCDSS attempted to discuss the subject child's dire condition, the mother would hang up. Despite this information, SCDSS unfounded the allegation of Inadequate Guardianship against the mother on the report that was open at the time of the death and closed the case on 6/24/22.

PIP Requirement

For citations identified in historical cases, SCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS 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

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 SCDSS gathered, they determined there was no reasonable cause to suspect the death was a result of abuse or maltreatment and closed the investigation opened at the time of the fatal incident on 6/24/22.

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: 05/23/2022 **Time of Death:** 04:48 PM

Date of fatal incident, if different than date of death: 05/10/2022
Time of fatal incident, if different than time of death: 03:00 AM

County where fatality incident occurred: Steuben
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
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: Birth

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	13 Day(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	29 Year(s)
Other Household 1	Father	No Role	Male	26 Year(s)

LDSS Response

On 5/23/22, SCDSS learned of the subject child's death and within 24 hours notified the Rochester Regional Office, submitted the required 7065 Agency Reporting Form, interviewed the household members, and conducted a home visit.

SCDSS was aware the subject child was in critical condition after her birth and were in regular contact with hospital staff to receive medical updates and assist in facilitating discussions with the mother. The subject child had multiple organ failures, including her lungs, kidneys, and liver. The subject child required numerous medical interventions to keep her alive. The hospital physician ultimately reported that the subject child was in pain and would not survive without continued medical intervention. The mother would not acknowledge the severity of the subject child's situation or take necessary next steps for her medical care. Hospital staff reported the subject child was suffering physical pain as her condition worsened. After numerous unsuccessful attempts to contact the mother in the days preceding the subject child's death, she finally agreed to end supportive care on 5/23/22 and the subject child passed away at the hospital.

Law enforcement responded to the residence after a 911 call was received and observed the mother awake, alert, and sitting in a chair holding the subject child. The bathtub that the subject child was born in was observed to be rusty and dirty.

The mother initially denied knowledge that she was pregnant; however, the paternal grandmother reported the mother briefly received prenatal care while she resided in Florida with the alleged father.

The mother reported punching herself in the stomach repeatedly with a closed fist the night before she gave birth to the subject child. When asked why the mother did this, she reported that it was to regulate her menstrual cycle and because she had "boy parts." The documentation did not provide clarification on what the mother meant by this. The hospital physician stated that this could have resulted in preterm labor; however, the condition of the subject child and her subsequent death were more likely attributed to the two-hour delay in medical care from being born at home in a remote location and then being airlifted to a hospital further away.

Grief services were offered to the family and an Adult Protective Services referral was made on behalf of the mother due to on-going untreated mental health, housing instability, and a self-reported history of substance use. Adult Protective Services was actively working to get the mother into counseling at the time the CPS investigation closed on 6/24/22.

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: Other physician

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Steuben 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?	☒	☐	☐	☐

Additional information:
This was not an SCR reported fatality; however, relevant collateral sources, including law enforcement and hospital staff were interviewed, and medical records were obtained.

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: Adult Protective Services							
Additional information, if necessary: Following the SC's death, SCDSS made a referral to Adult Protective Services on behalf of the SM due to her on-going untreated MH. SCDSS was working to get the SM engaged in MH counseling and the SM had an appointment scheduled with a MH counselor; however, the SM did not attend this appointment and was not yet engaged with MH services.							

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief resources were provided to the SM following the SC's death, and the SM was encouraged to engage in MH counseling. An APS referral was made on behalf of the SM for on-going untreated MH.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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)
05/10/2022	Deceased Child, Female, 0 Days	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The SCR report alleged that on 5/10/22, the mother gave birth to the subject child. The mother had two children removed from her care in the past that had not been returned to her. One of the children was removed at birth due to concerns regarding the mother's ability to care for a newborn. The mother had a history of substance use.

Report Determination: Unfounded **Date of Determination:** 06/24/2022

Basis for Determination:
SCDSS unsubstantiated the allegation of IG against the SM. The SC was born prematurely in the bathtub of the SM's home and in critical condition. EMS airlifted the SC to the hospital. The SM did not understand the severity of the situation or discuss necessary steps with the hospital. Medical staff reported that the SC's condition was not the result of the mother's actions but was due to the length of time before receiving medical care and being born in a remote location. Supportive care ended and the SC died on 5/23/22 at the hospital. The SM surrendered her rights to two other children. The SM had a history of untreated MH, was unstable, and a self-reported history of substance misuse.

OCFS Review Results:
SCDSS initiated their investigation within 24 hours by contacting the source of the report, completing a home visit, and interviewing household members. A CPS history check was completed and SCDSS maintained contact with medical staff regarding the SC's condition throughout the investigation. Upon learning of the SC's death during the open investigation, SCDSS conducted further interviews regarding the circumstances surrounding the SC's death; however, the record did not reflect that EMS was contacted, despite the pertinent information they could have had regarding the timeline following SC's birth.

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

Issue:
Appropriateness of allegation determination

Summary:
The allegation of IG was unsubstantiated against the SM. It was documented throughout the investigation that the SM did not communicate with medical staff to make necessary medical decisions for the SC, resulting in the hospital contacting their ethics team. When the SC was in distress and in physical pain, the SM could not be reached for 5 days and would

hang up when attempts were made to discuss the SC's condition. The SM did not establish a plan for the provision of the SC's medical care.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

SCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Rochester Regional Office if further guidance is needed.

[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.

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