Child Fatality Report

Report Identification Number: SY-17-035

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

Issue Date: Nov 06, 2017

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: 3 day(s)
Jurisdiction: Tompkins
Gender: Male
Date of Death: 08/02/2017
Initial Date OCFS Notified: 08/03/2017

Presenting Information

An SCR report was received on 8/2/17. The report alleged the SM delivered the SC at home on Sunday, 7/30/17. When the SC was delivered at home there was no medical evaluation at the time of birth. The SM attempted to breastfeed, but the SC wouldn't eat for the first 36 hours of life. On 8/1/17 the SC became lethargic and he was breathing rapidly. The SM and SF waited at least six more hours to bring the SC to the hospital. The SC arrived at the hospital just before 7:00pm on 8/1/17. The baby passed away at 2:35am on 8/2/17. The SM and SF refused to have an autopsy preformed. The SM and SF's failure to seek medical treatment for the SC in a timely manner contributed to his death.

Executive Summary

This report concerns the death of the 3-day-old SC. Tompkins County Department of Social Services (TCDSS) received an SCR report concerning the fatality on 8/2/17. The report alleged the SM and SF failed to provide the SC with adequate nutrition and did not seek medical attention for the SC when necessary, thus contributing to his death. TCDSS learned the SC had no surviving siblings. The SC, SM and SF all resided together in a home shared with other members of a religious community. The community members pooled resources so together the needs of everyone were met. The SM did not receive medically based prenatal care. The SM followed a regimen of vitamins and made sure she received proper nutrients throughout her pregnancy with the SC. The SM's pregnancy and birth of the SC was uneventful and the SC was believed to be healthy upon birth. By all accounts, the SC was breastfeeding and was an alert and responsive baby up until the day he died. On the day of the fatality, the SC was observed with labored breathing. In the hours leading up to his death, his skin color changed and he eventually fell limp and unresponsive. The SM and SF took the SC to the ER for treatment. The SC had not been seen by a doctor before the fatal event.

The ME performed an autopsy of the SC. The ME determined the cause of death to be a congenital heart defect and the manner of death to be natural causes. The ME told TCDSS that even if the SM and SF had taken the SC for medical treatment when he initially showed signs of distress, no medical treatment would have prevented his death. The ME further reported that if the SM had medical prenatal care the heart condition may have been detected, but the untimely death of the SC would have been unavoidable.

LE jointly investigated the fatality with TCDSS. The DA was also kept informed throughout the investigation. LE did not find the SM and SF to be criminally responsible for the death of the SC based on the ME's findings.

TCDSS made several visits to the home of the SM and SF. In addition to interviewing them, TCDSS also spoke with every person with information about the birth and death of the SC. TCDSS found evidence the SC was being provided with proper nutrition. TCDSS also found that the SM and SF sought medical attention for the SC when his health was at imminent risk. TCDSS appropriately unsubstantiated the allegations of DOA/Fatality, IG and IF/C/S against the SM and SF, based on the evidence they gathered.

Throughout the investigation TCDSS showed respect and compassion when speaking with the SM and SF about their unconventional beliefs regarding pregnancy, child birth and medical intervention. TCDSS built rapport with the SM and SF. The SM and SF were initially opposed to an autopsy, but TCDSS was able to convince them to agree to an autopsy of the SC. Consequently, after learning of the SC's heart condition, the parents spoke with a doctor from the ME's office. Through that conversation, the SM and SF gained valuable knowledge about future pregnancies and births. The SM and

SF were planning to have more children and told TCDSS they would be seeking traditional prenatal care in future pregnancies in an effort to be informed and have healthy children. TCDSS did offer the SM and SF bereavement services, but the SM and SF declined. The SM and SF were receiving grief support from the other adults in their community. TCDSS did not identify any further service needs at the time of the case closure.

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?** Yes

Determination:

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

Was the decision to close the case appropriate? Yes
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:
There was sufficient information gathered to determine the allegations. The case closure was appropriate.

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: 08/02/2017 **Time of Death:** 02:35 AM

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

County where fatality incident occurred: Tompkins
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
How long before incident was the child last seen by caretaker? 1 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Alleged Victim	Male	3 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)

LDSS Response

Upon receiving an SCR report regarding the death of the SC on 8/2/17, TCDSS began an investigation. TCDSS contacted the source, LE, DA, ME and medical staff during their investigation. TCDSS learned the SM gave birth to the SC at home on 7/30/17 with the assistance of the SF and family friends. The SC was the first born child for both the SM and SF. The SM, SF and SC lived in a home with members of a community group. The SM, SF and SC had their own living quarters within the home. TCDSS did not identify any other infants as living in the home. TCDSS learned through internet research and interviews that the community was a religion-based, self-supporting and members participated in communal living. TCDSS also learned that home births are common within the group and homeopathic medicine is preferred. The SM and SF were clear that medical intervention is readily sought when needed. The SM and SF do not use alcohol or drugs because it is in opposition of their values.

TCDSS and LE went to the home of the SM and SF to discuss the events leading of to the SC's death. TCDSS made several visits to the home. At the first visit, the SF was interviewed in the presence of 2 other female home members (OA1 and OA2). The SF reported the SM's pregnancy, labor and delivery with the SC went well, absent of any complications. The SF recalled the SC cried immediately upon birth and everything appeared normal. The OA1 reported the SM was breast feeding and initially the SC was having trouble latching on, but eventually figured it out and fed regularly. The SF reported he and the SM were the primary caregivers for the SC, but acknowledged the other female adults in the home helped as well. The SF took the SC to the hospital about 4 hours after his odd breathing began.

Upon subsequent home visits TCDSS interviewed the other home members that had information regarding the birth and care of the SC. TCDSS learned when the SC was born there were 4 unrelated adults present in addition to the SF. None of the adults had any formal child birth training; rather, they drew from their own birthing experiences while assisting with the SC's birth. TCDSS learned the SC was born healthy and there were no concerns or complications with delivery. The SC was nursing frequently, but would often fall asleep during feedings. The SC reportedly had 3 bowel movements and was urinating. OA2 expressed she thought the SC should have been urinating more, but attributed this to his intake during

feedings. The hope was the SM would have produced more breast milk and the feeding would have improved. The SC was described as alert, but difficult to wake at times.

The SM also reported the SC was nursing in brief intervals, but had a healthy bowel movement on 8/1/17 at about 12:30PM. The SM said at that time she gave him a bath and was confident the results of nursing were improving. The SC was restless after the bath and the SM noticed his breathing was strange at around 2:00PM. The SM said his breaths were fast and he was making a grunting noise. The SM and SF then began to notice the SC's color was changing, and the SF brought him outside because there was a concern it may be due to jaundice. During this time one of the other adults called people within the community for advice. Over a period of 2-3 hours the SM and SF prayed for the SC's health and when it did not improve, they sought medical attention. The SM and SF knew something was terribly wrong when the SC became lethargic and his breathing worsened. The SC began to go limp and was taken to the ER at about 6:00PM.

TCDSS learned the SC was immediately admitted to the hospital upon arrival. Multiple tests were performed and the SC was placed on life support and his condition continued to deteriorate. After discussion with the doctor the SM and SF made the choice to withdraw life support and the SC passed an hour later. The SM and SF were holding the SC and grieving as expected at the time of his death.

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 investigation conducted by a Multidisciplinary Team (MDT)?Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041581 - Deceased Child, Male, 3 Days	041583 - Father, Male, 29 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
041581 - Deceased Child, Male, 3 Days	041583 - Father, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
041581 - Deceased Child, Male, 3 Days	041582 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
041581 - Deceased Child, Male, 3 Days	041583 - Father, Male, 29 Year(s)	Lack of Medical Care	Unsubstantiated
041581 - Deceased Child, Male, 3 Days	041582 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
041581 - Deceased Child, Male, 3 Days	041582 - Mother, Female, 25 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
041581 - Deceased Child, Male, 3 Days	041583 - Father, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated

Child Fatality Report

041581 - Deceased Child, Male, 3 Days	041582 - Mother, Female, 25 Year(s)	Lack of Medical Care	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
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	Needed but 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:
TCDSS had a thoughtful conversation with the SM and SF regarding planning for future pregnancies. The parents reported they spoke with the ME about this issue and were given recommendations. They reported they plan to seek prenatal care in the future pregnancies, in an effort to detect any fetal abnormalities and seek appropriate medical care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The SM and SF were offered services, but declined.

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? 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? No
Was the child acutely ill during the two weeks before death? No

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 fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

There is no known CPS History outside of New York State.

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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