Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-19-045

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

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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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Seneca
Gender: Male
Date of Death: 12/09/2019
Initial Date OCFS Notified: 12/17/2019

Presenting Information

The 1-month-old subject child was born with a genetic heart defect and other medical complications. The subject child was born on 10/25/19, and had heart surgery shortly after; however, the subject child suffered multiple strokes and complications following the surgery. The subject child subsequently died on 12/9/19. The subject child had been in the hospital since birth.

Executive Summary

On 12/16/19, Seneca County Department of Social Services (SCDSS) notified OCFS of the subject child's passing through the required 7065 Agency Reporting Form. SCDSS first learned of the subject child via an SCR report received on 10/28/19 that alleged parent drug/alcohol misuse against the mother for the subject child. The mother gave birth to the subject child on 10/25/19 and tested positive for marijuana. The subject child was diagnosed in utero with a genetic heart condition that required surgery. Shortly after the subject child was born, he was transferred to another hospital, where he had heart surgery. The subject child suffered multiple complications after his surgery and died on 12/9/19 at 4:00 PM. The subject child remained in the hospital since birth.

SCDSS determined there were no surviving siblings or other children residing with the parents at the time of the subject child's death. SCDSS learned the father of the subject child had another child from a previous relationship. SCDSS verified the child never met the subject child. The father told SCDSS he had not visited with the half sibling of the subject in a long time.

It was determined after consultation with medical professionals that the subject child died due to complications from his heart surgery and an autopsy was not needed. SCDSS spoke with several treating physicians and obtained and reviewed the medical records.There was no reasonable cause to suspect the parents' actions or inaction contributed to the death of the subject child.

SCDSS met all NYS regulations and requirements pertaining to casework contacts, safety assessments, and the provision of services in the investigation dated 10/28/19. SCDSS appropriately unsubstantiated the allegations of Parents Drug/Alcohol Misuse. This case is addressed in the history section of the fatality report.

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:
SCDSS gathered sufficient information to close their investigation that was open at the time of the subject child's death.

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 notes a consultation took place, but no details noted.

Explain:
SCDSS gathered sufficient information to close their case that was open at the time of the subject child's passing.

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: 12/09/2019 **Time of Death:** 04:00 PM

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? N/A
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
At time of incident supervisor was: Unknown if they were 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	Male	1 Month(s)
Deceased Child's Household	Father	No Role	Male	29 Year(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)

LDSS Response

On 12/9/19, SCDSS was notified of the death of the subject child who was hospitalized and died due to medical complications on 12/9/19. There were no allegations reported as a result of the death. SCDSS gathered information from medical professionals and provided the information to OCFS on 12/16/19, through form 7065 as per regulation.

The subject child was born on 10/25/19 with a heart defect that required surgery. The subject child was transferred to another hospital shortly after his birth. After the subject child's surgery, he suffered multiple strokes and had further complications which resulted in his death on 12/9/19. The subject child was a medically fragile child and had been in the hospital since birth.

SCDSS received an SCR report on 10/28/19, alleging the mother tested positive for marijuana during her pregnancy with the subject child. The following activities were conducted by SCDSS prior to the subject child's passing. SCDSS spoke with family, friends and the mother's treatment providers and there were no concerns regarding the care of the subject child by the mother. SCDSS completed a plan of safe care with the parents. SCDSS observed the home and there was no evidence of drug/alcohol misuse and there were no noted safety hazards in the home. SCDSS appropriately went over safe sleep practices with the family and provided literature on safe sleep. SCDSS observed the crib and found it to be appropriate. The mother had all the appropriate supplies for the subject child's anticipated release from the hospital; however, the subject child died never came home, and died in the hospital.

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: Seneca County Department of Social Services does not have an OCFS approved CFRT.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
There was an open investigation at the time of the subject child's passing. The mother was engaged in appropriate services for her mental health. The mother had disclosed her partner was abusive towards her in the past and SCDSS provided her with referrals to their local Domestic Violence program. This was done prior to the subject child's passing during the open investigation.

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)
10/28/2019	Deceased Child, Male, 3 Days	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	No

Report Summary:
The SCR report alleged the mother gave birth to the subject child and the mother's toxicology tests revealed the mother was positive for marijuana.

Report Determination: Unfounded
Date of Determination: 01/06/2020

Basis for Determination:
The allegation of PD/AM was unsubstantiated against the mother. The subject child did not test positive and there was no impact to the subject child due the mother's use of marijuana. The mother had mental health issues and took multiple

medications which she stopped taking while pregnant. After the birth of the subject child the mother resumed her treatment. The mother admitted she had misused drugs in the past and was in a treatment/counseling program. SCDSS verified this with her treatment program. SCDSS completed a plan of safe care with the parents. The subject child remained in the hospital since birth and died due to a genetic heart condition. The case was unfounded and closed.

OCFS Review Results:
SCDSS gathered a substantial amount of information from collateral contacts by way of face-to-face interviews, telephone contacts, and copies of records. The information gathered supported the basis for unfounding the report. SCDSS spoke with familial and collateral contacts to obtain information about the fatality, and determined there was no reasonable cause to suspect the death was a result of abuse or maltreatment.

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

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

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

Known CPS History Outside of NYS

There was no known history outside of NYS.

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