Child Fatality Report

Report Identification Number: SY-17-028

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

Issue Date: Nov 07, 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 month(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 07/05/2017
Initial Date OCFS Notified: 07/05/2017

Presenting Information

An SCR report was received on 7/5/17 regarding the death of the 3-month-old male SC. The report alleged the SC had a medical condition for which he was prescribed medication. The SM was not providing the medication to the SC. The failure of the SM to provide the medication to the SC contributed to his death. The SM had not notified EMS or other authorities of the death when the report was made. The SC's residence posed a physical hazard to the SC and his 1-year-old SS. The residence was filthy with accumulations of garbage, dirty clothes and dirty dishes. The residence was also infested with bed bugs and the SC and SS were covered in bug bites.

Executive Summary

This report concerns the death of a 3-month-old male. Oneida County Department of Social Services (OCDSS) learned the SC died on 7/5/17, after receiving an SCR report that same day. The report alleged that the SC was born with a medical condition that required medication and the SM was failing to give the SC his medication as prescribed. It was further alleged that the physical condition of the SM's home posed a hazard to the SC and SS. The BF had been incarcerated since November of 2016, therefore he did not live in the home at the time of the SC's fatality. OCDSS correctly added the BF to the SCR report, however OCDSS made him a subject in error.

The SM, SC and SS slept at the MGM's home on 7/4/17. The SM woke to the SC crying and prepared him a bottle with one of his three medications in it. The SC would not take the bottle and the SM reported the SC then struggled to breathe. The SM discovered the SC had stopped breathing and the MGM came to the room to help. The SM called 911 while the MGM attempted to resuscitate the SC. EMS responded and the SC was taken to the hospital. The efforts to save the SC were unsuccessful.

LE was notified of the fatality and after a preliminary investigation they determined there was no criminality surrounding the fatal incident. LE did not proceed further with an investigation as they believed the death of the SC was due to medical complications. The ME was also notified and an autopsy was done. The cause and manner of death were pending toxicology, cultures and a metabolic screen at the time this report was written.

OCDSS saw the SS within hours of the notification of the SC's death. OCDSS closely monitored the condition of the home and the SM's care of the SS throughout the fatality investigation and a subsequent SCR report. As a result, OCDSS appropriately consulted their legal department and filed a neglect petition against the SM regarding the the SS. The Family Court issued COS as a result of the Neglect Petition and OCDSS opened a long term CPS services case to monitor the SM's participation in services and offer continued support to the family. The SM made a plan for the SS to stay with the PGM during the investigation and the PGM filed for custody of the SS. The custody and neglect were heard together in court and the matter was ongoing at the time this report was written.

During the investigation, OCDSS spoke with the SM, MGM, PGM, pediatrician, visiting nurse, a service provider from Healthy Families and the specialized care physician that coordinated the care and medication for the SC. OCDSS discovered that the visiting nurses had monitored the SC for 2 months and closed the case. The nurse reported the SM was compliant with administering the SC's medication as evidenced by blood tests given regularly by the physician following the care of the SC. The worker from Healthy Families reported that the SM was cooperative with services. She reported the home was sometimes not clean and a bit cluttered, but she was working with the SM in these areas. The Specialist doctor working with the SC told OCDSS the SC's condition was not considered fatal and she suspected the SM was not

giving the SC medication as prescribed.

OCDSS discovered the SM had not refilled two of the three medications given to the SC since April of 2017. The doctor reported if these medications had been properly administered by the SM, the medication would have needed to be replenished in June 2017. The doctor expressed this is evidence of medication non compliance which may have caused life threatening complications for the SC.

OCDSS had not yet made a determination at the time this report was written. The ME was made aware of the doctor's concerns regarding the SC's medication. OCDSS was awaiting the final autopsy report (inclusive of toxicology reports) before making a determination in this case.

OCDSS offered several services to the SM, including funeral arrangements, MH and Drug Counseling.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The CPS investigation remained open at the time this report was written.

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:
The investigation remained open at the time this report was written and there was also an open services case and CPS was monitoring the SM and SS.

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: 07/05/2017 **Time of Death:** 03:56 AM

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

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: 02:50 AM
Did EMS respond to the scene? Yes
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
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 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	20 Month(s)
Other Household 1	Father	Alleged Perpetrator	Male	26 Year(s)

LDSS Response

After receiving an SCR report regarding the death of the SC on 7/5/17, OCDSS began an investigation. OCDSS contacted the source, LE, ME and the DA. OCDSS learned that LE would not be investigating further, because no foul play was suspected in the death of the SC.

OCDSS visited the SM and SS and learned that the SM, SC and SS slept at the MGM's home on 7/4/17, where the fatality

occurred. OCDSS visited the MGM's home and assessed the safety of the SS. OCDSS determined the SS was safe in the care of the SM and found the interactions between them to be appropriate. The SM, SS and SC had slept in a spare bedroom in the MGM's home the night the fatality occurred. OCDSS observed 2 pack and plays for the SC and SS. OCDSS reiterated safe sleep practices with the SM as she had previously received this information.

The SM told OCDSS she woke to the SC crying at about 2:00AM and she prepared a bottle for him. The SC was born with a congenital disorder that required he be given daily medications. The SM said she made the bottle and put the medication in it. The SC would not drink the bottle, and the SM said this sometimes happened. The SM said when this happened she normally gave the SC his medication separately from the formula, by giving it to him orally through a syringe. On the morning of the fatality the SM did not give the SC the medication separately. After the SC refused the bottle, the SM reports the SC then had trouble breathing. The SM stated at one point he stopped breathing altogether and she called for the MGM to help her. The MGM responded and advised the SM to call 911. The SM reports the MGM attempted to resuscitate the SC and the SC was foaming at the mouth. EMS responded to the home and continued CPR to no avail. EMS transported the SC to the hospital, where he was pronounced dead at about 4:00AM. The SM denied using any drugs or alcohol in the time leading up to the fatality. The SM also reported she always gave the SC his medications as she was supposed to and denied forgetting his medications the day of the fatal incident. The SM further reported the SC's doctor told her if he slept through a dose of medication, she could give him double the dose when he woke.

OCDSS spoke with the MGM about the events leading up to the fatality. The MGM reported her daughter took very good care of the SC and never forgot or withheld his medications. The MGM believed the SC died of medical complications. The MGM denied concern about the SM’s care of the SC, reporting she was attentive to the SC's medical needs. The MGM told OCDSS the SM struggled with housekeeping and would benefit from MH counseling.

OCDSS received a subsequent report regarding the drug use of the SM and her boyfriend around the SS. The SM submitted to 2 drug tests and she was positive for marijuana both times. The SM denied using drugs in the home or while caring for the SS. OCDSS also made several follow up home visits and found the home dirty. OCDSS also learned the SM had several MH concerns and was not complying with recommended treatment and medication. OCDSS filed a Neglect Petition against the SM in Family Court regarding the SS to address these issues. The SM was court ordered to supervision and directed to comply with MH treatment, refrain from drug use and keep the home clean. The SM was participating in MH and drug treatment services and had arranged for the SS to stay with the PGM. The SS remained there at the time this report was written.

OCDSS spoke with medical providers during the investigation. A specialist who treated the SC questioned if the SC received his medication properly and considered his death suspicious. Family members contacted also said the SM forgot to administer the SC’s medication and had to be reminded from time to time.

OCDSS learned the SF was incarcerated and had not been living with the SM, SC and SS for over a year. OCDSS visited the BF in prison and he had no new information regarding the death of the SC.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or 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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041141 - Deceased Child, Male, 3 Mons	041143 - Mother, Female, 22 Year(s)	Lack of Medical Care	Pending
041141 - Deceased Child, Male, 3 Mons	041143 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Pending
041141 - Deceased Child, Male, 3 Mons	041143 - Mother, Female, 22 Year(s)	DOA / Fatality	Pending
041142 - Sibling, Male, 20 Month(s)	041143 - Mother, Female, 22 Year(s)	Inadequate Food / Clothing / Shelter	Pending
041142 - Sibling, Male, 20 Month(s)	041144 - Father, Male, 26 Year(s)	Inadequate Guardianship	Pending
041142 - Sibling, Male, 20 Month(s)	041144 - Father, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Pending
041142 - Sibling, Male, 20 Month(s)	041143 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Pending

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:

EMS and ER staff were not contacted, but OCDSS gathered sufficient medical information regarding the fatality. OCDSS enlisted help from the county where the SF was incarcerated, and plans to interview him were underway at the time of this report.

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 safety 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?	☐	☐	☒	☐

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	☒	☐	☐	☐

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?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/28/2017	There was not a fact finding	There was not a disposition
Respondent:	041143 Mother Female 22 Year(s)	
Comments:	The initial court appearance was 8/2/17. The SM was not present because she did not receive service of the petition, and it was postponed till 8/23/17. 8/23/17-Initial appearance where all parties present, after the neglect petition was filed. The SM made a general denial to the allegations in the petition. An OP was requested by OCDSS; however a Temporary Order of Supervision was issued instead. The SM was to refrain from allowing alcohol or drug use around the SC, keep her home clean and attend all scheduled MH appointments. The next court date was 9/19/17. 9/19/17-Court regarding the neglect petition and a violation of the order of Supervision filed by OCDSS was adjourned until 11/2/17.	

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	☐	☐	☐	☐	☐	☒	☐

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 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)	Status/Outcome	Compliance Issue(s)
11/05/2015	Sibling, Male, 2 Days	Father, Male, 24 Years	Inadequate Guardianship	Indicated	No

Report Summary:
An SCR report was received alleging the BF became angry and physically assaulted the MGM in the presence of the SS (at the time a newborn child). The BF choked the MGM, picked her up, and brought her into the hospital room bathroom. The MGM sustained marks to her neck and was having difficulty breathing. The roles of the MGM and SM were unknown.

Determination: Indicated | **Date of Determination:** 01/28/2016

Basis for Determination:
OCDSS found that after the SS was born, the BF physically assaulted the MGM after the MGM slapped him for being disrespectful. The incident occurred in the hospital. The police were notified but no criminal charges were filed by the MGM. The SM and SS were in the room when the incident occurred. The SM was unable to intervene as she was confined to the hospital bed. OCDSS determined the SS was a risk of harm because the events took place in a small room. The BF was receiving MH services.

OCFS Review Results:
OCDSS made contact with everyone listed on the report and additionally contacted appropriate collaterals. Several home visits were made and OCDSS gathered information pertinent to the investigation. OCDSS checked for criminal and CPS history and completed safety and risk assessments timely and accurately. OCDSS made referrals to services that they believed would benefit the family. There was documentation of supervisory case reviews.

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

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

There is no CPS History 3 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