NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-14-018 **Prepared by: Rochester Regional Office**

Issue Date: 5/5/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 3 day(s)
Jurisdiction: Ontario
Gender: Male
Date of Death: 09/01/2014
Initial Date OCFS Notified: 09/15/2014

Presenting Information

On 9/15/14 Ontario County Department of Social Services (OCDSS) received an initial report regarding the death of the subject child. According to the narrative of the report, on 8/29/14, the BM gave birth to a baby girl. On 8/31/14, the infant went into distress while at the hospital in the sole care of the BM. The infant was transferred to another hospital in a neighboring county where she passed away on 9/1/14 at 8:31 am. The infant was an otherwise healthy baby who died. The role of the father was listed as unknown. It should be noted that the subject child was actually a male and the medical records indicate that the child died at 9:40 pm after being removed from the ventilator at the request of the BM and BF.

Executive Summary

This fatality report concerns the death of a 3-day-old male that occurred on 9/1/14. OCDSS received an initial report in regards to the death of the child on 9/15/14 with allegations of Dead on Arrival/Fatality (DOA/FAT) and Inadequate Guardianship (IG). The mother was listed as the subject of the report. The BF was listed with an unknown role.

According to the report, on 8/29/14, the BM gave birth to a baby girl. On 8/31/14, the infant went into distress while at the hospital in the sole care of the BM. The infant was transferred to another hospital in a neighboring county where she passed away on 9/1/14 at 8:31am. It should be noted that according to medical records, the subject child was a male and died at approximately 9:40 p.m. after being removed from a ventilator at the request of the BM and BF.

OCDSS worked jointly with law enforcement and completed an adequate investigation. According to 4 medical doctors the actual cause of death was unknown as a full autopsy was not completed. The preliminary autopsy report suggested that the SC had acute bronchitis and a bacterial infection. The death certificate lists the immediate cause of death as anoxic brain injury due to a consequence of sudden infant death syndrome. OCDSS appropriately unsubstantiated the allegations as no credible evidence was found to suggest that the mother failed to provide a minimum degree of care or caused the death.

The report was closed on 12/19/14 with a very high final risk rating as the death of the child was listed as an elevated risk. The RRO does not agree with the final risk rating based on the fact that the elevated risk rating was not accurately completed; therefore a required action was issued. According to the Risk Assessment Profile (RAP) completed by OCDSS, the subject child died as a result of maltreatment by the caretaker. This is contrary to the report determination, death certificate, and medical opinions of the child's death. According to the explanation listed in the RAP, “the subject child died of lack of oxygen to the brain and due to the fact that the BM was unable to explain this and was the sole caretaker at the time of the child’s death, it appears as maltreatment”. As per several medical doctors and the death certificate, the child’s death was unexplained therefore the death of the child should not be listed as a risk factor.

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.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The RRO does not agree with the final risk rating does not support the facts of the case.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(b)
Action:	RRO is aware of current policies and practices being implemented to address adequate completion of Risk Assessment Profiles. No further action required.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/01/2014 **Time of Death:** 09:40 PM

County where fatality incident occurred: MONROE
Was 911 or local emergency number called? No
Did EMS to 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: Child died once removed from the ventilator.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)

LDSS Response

OCDSS completed and approved the initial 24 hour safety assessment on 09/16/14. The decision selected was #1 as no safety factors were present and there were no surviving siblings within the households. As a result, a safety plan was not required. Between 9/15/14 and 9/16/14 OCDSS and LE interviewed the BM, BF, attending medical staff, the medical director of the medical examiner's office, and a medical physician that specializes in abuse and maltreatment at the local Child Advocacy Center. OCDSS consulted with various medical physicians in an attempt to determine whether or not the SC death was caused from abuse and/or maltreatment. This was due to the fact that the BM was the sole caretaker at the time of the incident leading up to the death of the SC. In addition, medical staff reported that the BM acted suspiciously when the SC was in distress as she did not immediately alert hospital staff when the child was in distress and during their interventions, the BM displayed very little emotion.

It was determined that the SC was born via normal spontaneous vaginal delivery on 8/29/14 and transitioned without incident. At about 1:30 am on 8/31/14, the BM breastfed the SC and spoke to the BF on the telephone for about 10 minutes. The BF reported that he overheard the mother feeding and burping the SC. Afterwards the BM rocked the SC and then placed him on top of a boppy pillow to change his diaper. Upon unwrapping the SC from a swaddled blanket the BM noticed that his nails were purple in color. The BM alerted hospital medical staff by turning on the call bell. Medical staff responded to the room and found the SC in distress with an undetectable heart rate. Hospital staff called a code at 2:15 am and provided chest compressions until about 2:35 am as the SC's heart rate was over 100. The SC was intubated at 2:37 am. The NICU team responded and transported the SC to a hospital in a neighboring county for further treatment. The SC arrived at the hospital at 3:57 am and it was determined that he was without respiratory effort. According to hospital records, the MRI showed extensive brain stem and internal capsule injury. On 9/1/14 the parents signed a Do Not Resituate (DNR) form. The SC was treated for comfort care and extubated at 9:37 pm. The SC died at 9:40 pm. The BM denied falling asleep while holding the SC; however she has been inconsistent with this detail. The BM also denied having knowledge of any other accident that could have contributed to the death.

The provisional autopsy findings were hypoxic ischemic encephalopathy or lack of oxygen to the brain, acute bronchitis as fluid was found on the lungs and a positive blood culture for some type of bacterial infection. No trauma was observed to

the body. According to 4 different medical physicians the cause of the SC's death was unknown and unexplainable without conducting a full autopsy to examination. The parents opted not to have a full autopsy report. The medical examiner's office did not require a full autopsy due to the fact that the death was attended by medical providers. One of the physicians did report that bacteria in the blood or acute bronchitis can cause an infant's death as per the preliminary autopsy report. The specialty medical physician that specializes in child abuse and maltreatment cases suggested that the child could have positional asphyxiation could explain lack of oxygen to the brain however clarified that this was an opinion based on review of medical records only. This physician did not have the benefit of examining the SC's body. It remains unknown what exactly caused the child to lose oxygen to the brain.

OCDSS obtained a copy of the SC's death certificate. According to the death certificate, the immediate cause of death was anoxic brain injury due to a consequence of Sudden Infant Death Syndrome (SIDS).The report was unfounded and closed on 12/19/14. Criminal charges were not filed by law enforcement.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Hospital physician

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
014161 - Deceased Child, Female, 3 Days	014162 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
014161 - Deceased Child, Female, 3 Days	014162 - Mother, Female, 30 Year(s)	Inadequate Guardianship	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 Unavaliable	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

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

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

The BF of the subject child is listed in a total of 4 previous CPS investigations that occurred more than three years before

the fatality between 2006 and 2011. The alleged maltreated children in all of the reports were three older-half siblings of the subject child and an un-related child. In all but 1 report, the BF was listed as a subject. The other subjects listed were the mothers of the subject child's half siblings. The allegations listed were EDNG, IG, PDRG, IFCS, LSUP and IFCS. All of the reports were unfounded except for a report in 2010 which alleged that the BF endangered the welfare of his child and the child of his girlfriends as he drove away from the scene of an accident while under the influence of alcohol. The BF was arrested and charged with Endangering the Welfare of a Child and Driving While under the Influence.

Known CPS History Outside of NYS

No known history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

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.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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