Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-17-050

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

Issue Date: May 10, 2018

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		

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Case Information

Report Type: Child Still Born
Age: Unknown
Jurisdiction: Wayne
Gender: Female
Date of Death: Unknown
Initial Date OCFS Notified: 12/26/2017

Presenting Information

The SCR report alleged that on 12/26/17, the mother abused cocaine causing a placenta abruption, forcing the mother to go into labor at home. The female newborn passed away shortly after birth. The child's death was suspicious due to mother's drug use and no other signs of trauma to the child. The role of the unrelated home member (name unknown) was unknown.

Executive Summary

This fatality report concerns a child who was stillborn on 12/26/17. A report was made to the SCR on the same date regarding mother's drug use and the child's death. There were no surviving siblings or other children living in the home. Mother had a 14yo daughter who had been in the care of her father in another county since 2009, and did not have contact with the child in several years. The 14yo SS went to live with her father due to mother's substance abuse issues.

Wayne County Department of Social Services (WCDSS) coordinated efforts with LE upon receipt of the fatality report. Secondary assignments were given to Monroe County Department of Human Services (MCDHS) as mother was in the hospital in Rochester, and Broome County Department of Social Services (BCDSS) to assist in locating the mother's 14yo daughter. BCDSS made diligent efforts but was unsuccessful in locating the 14yo.

The mother reported she had back pain on 12/26/17, then took a nap, and continued to have complications so she called 911. When EMS and LE arrived, they help deliver the child. EMS and two LE officers never saw the child take a breath, move, or show any signs of life. Revival efforts were made and the child could not be brought to life. The mother was taken to the hospital for post-delivery treatment and was observed to have had a placental abruption, which hospital staff said can be caused by cocaine use. The mother admitted to using cocaine on 12/25/17. EMS and LE observed white powder and razor blades in the mother's home.

WCDSS gathered information about the child's death from EMS, LE, the hospital, and mother. CW contacted also contacted the mother's substance abuse recovery program who confirmed the mother had a history of substance abuse and had tested positive for cocaine in recent history.

MCDHS interviewed the mother while she was in the hospital and after that, she was unable to be located. WCDSS made notable efforts to locate the mother but were unsuccessful therefore services were unable to be offered. The mother had no CPS history. WCDSS completed required reports and safety assessments accurately and on time and completed an extremely thorough investigation.

An autopsy was performed; however, the ME's report was pending at the time of this writing.

WCDSS made the appropriate determination and unsubstantiated the allegations against the mother regarding the child's death. The child was not deemed to have been alive upon delivery or any time after.

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:
The casework activity as commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

On 12/26/17, WCDSS received the fatality report from the SCR. WCDSS initiated their investigation within 24 hours and coordinated efforts with LE. WCDSS contacted the source of the report, completed a CPS history check, and notified the ME and DA of SC's death. There were no surviving siblings or other children living in the home. There was a 14yo SS who had been in the custody of her father since 2009 and did not have contact with the mother.

The mother went to a hospital in Monroe County after the child was delivered stillborn at home and the Monroe County Department of Human Services (MCDHS) was assigned a secondary role. On 12/27/17, MCDHS went to the hospital to interview the mother and offer condolences. The mother claimed that on the night of 12/25/17, she used cocaine and then

went to bed. The mother said she woke up around 10AM on 12/26/17, ran errands, came home and took a nap. When she woke up that day, she said she was having back pain that moved to her front and when she got up to use the bathroom there was a "huge gush of blood." She said this is when she contacted 911. The mother claimed everything had been fine before this and she began prenatal care at 6 weeks. The mother said she had not seen or spoken to the father of the child in a while as he was in prison and had been there for about a month. The mother said she had a 14yo daughter who lived in another county with her father and she had not had contact with the child in several years. When asked why the child is not with her, the mother said it is because she is a heroin addict. The mother disclosed she had not used heroin for a year and was in a counseling and recovery program. The mother did admit to using cocaine a few times within the last year. She had been involved in her recovery program since May 2017. The mother denied having any guns or weapons, DV in her life or any mental health concerns.

WCDSS interviewed the medic and two LE officers who were present the day mother delivered, all of whom agreed the child was stillborn. The three collaterals said they never saw the child take a breath, the child had no pulse, did not move, and did not respond to any stimulation. One of the LE officers also described the child appeared blue. The medic said the home was messy with razors and white powder on an end table. The medic performed CPR for five minutes and then called a doctor at the hospital. The doctor instructed him he no longer needed to perform CPR.

Broome County Department of Social Services (BCDSS) was assigned a secondary role to assess the safety of the 14yo SS. The SS and her father were unable to be located. WCDSS and BCDSS made exceptional efforts to locate this child and her father and were unsuccessful.

WCDSS verified the father of the stillborn child was in prison and provided him with notification of the report.

WCDSS obtained records from the mother's substance abuse program and spoke with the agency. The mother tested positive for cocaine and marijuana at every test between November 2017 and January 2018.

Upon examination of the mother at the hospital, it was concluded she had a placental abruption. WCDSS contacted hospital staff as collaterals and they said cocaine use can cause placental abruptions and in a matter of minutes the baby can die.

The mother had no CPS history. LE attempted to get blood work from the mother at the hospital but she refused. LE had not filed any charges against the mother at the time of this writing. This case was unfounded and closed on 3/2/18. Since the child was not alive upon delivery or any time thereafter, the allegations were unsubstantiated.

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
045669 - Deceased Child, Female,	045670 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
045669 - Deceased Child, Female,	045670 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

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045669 - Deceased Child, Female,	045670 - Mother, Female, 33 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐

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	☒	☐	☐	☐

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:
The mother was already in a substance abuse treatment program. She was interviewed once while in the hospital and then could not be located after discharge to assess the need for services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Mother was in the hospital for a few days after delivery and was unable to be located after being discharged from the hospital.

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

Known CPS History Outside of NYS

There was no known CPS 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