Child Fatality Report

Report Identification Number: SY-20-017

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

Issue Date: Aug 20, 2020

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	

Case Information

Report Type: Child Deceased
Age: 5 day(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 05/04/2020
Initial Date OCFS Notified: 05/05/2020

Presenting Information

Onondaga County Department of Social Services (OCDSS) received an SCR report on 4/30/20 alleging that the mother, aged 17, gave birth to a baby boy on 4/29/20. The baby was born with a positive toxicology for marijuana. The child was born premature at 27 weeks gestation and was transferred to the NICU for pulmonary complications. The baby was expected to remain hospitalized for the foreseeable future. The child passed away on 5/4/20. Onondaga County was informed of the death of the child by hospital staff and informed the Syracuse Regional Office of the child's passing via the 7065-Agency Reporting Form on the same date.

Executive Summary

This report concerns the death of a 5-day-old child. The child was born premature at 27 weeks gestation and was hospitalized in the NICU for the entirety of his life. The child was born on 4/29/20, with a positive toxicology for marijuana. There were no surviving siblings; however, the mother was residing with a friend and her 2 children. Those children were assessed to be safe during the investigation.

OCDSS initiated their investigation upon receipt of the SCR report on 4/30/20. OCDSS was informed that the child was transferred to the NICU due to pulmonary complications requiring a chest tube. The mother discharged herself from the hospital against medical advice with plans to visit the child for up to 4 hours a day as allowed by hospital rules. OCDSS was informed by the hospital that the child passed away on the morning of 5/4/20.

OCDSS interviewed the mother in the home where she was staying. The mother admitted to regular marijuana use throughout her pregnancy. The mother stated that when she moved from Florida to New York, the father of the child was incarcerated in Florida.

OCDSS gathered information regarding the child's death from the hospital staff. An autopsy was not completed, as the death was the result of medical complications due to prematurity. The official cause of death was listed in medical notes provided to OCDSS to be, "prematurity 27 weeks, gram negative sepsis, respiratory distress with left pulmonary interstitial emphysema, metabolic acidosis, hypotension, and bilateral grade 4 IVH, also known as intracranial hemorrhage."

During the investigation of the initial SCR report concerning the mother's positive toxicology, there was no evidence the child's death was the result of abuse or maltreatment, therefore no SCR report was made regarding the child's death.

Although the mother was the alleged subject of the initial report, she was also 17 years old at the time. Her mother reportedly lived in the Syracuse region and was not contacted by OCDSS. Her father, who lives in Florida, flew to New York to be with the mother following the birth of the child and assisted with funeral arrangements following the death of the child. The father was interviewed during the investigation. There were multiple concerns disclosed for the mother potentially being the victim of child sex trafficking. OCDSS made a referral to the Safe Harbor program on behalf of the mother and offered appropriate services in relation to the child's passing prior to closing their investigation.

During the investigation OCDSS was made aware of multiple concerns for the mother potentially being the victim of child sex trafficking. The mother was a minor at the time the report was received by OCDSS. OCDSS did not intervene on behalf of the mother by taking any actions to ensure her safety or make a child protective report on her behalf against the

grandparents, who were aware of the concerns identified for her and failed to act on. OCDSS did not obtain demographic information for all members of the household, including the mother's reported paramour who lived in the home and had direct contact with them by phone and in person. OCDSS did not interview or document that the biological father of the other children named in the report was notified of the report despite adding him to the case record.

PIP Requirement

This review resulted in a citation related to casework practice. In response, OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

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:

While the BM was not an alleged victim, she was a minor at the time of the report. There were multiple concerns disclosed to OCDSS for the mother's mental health, drug use, potential illegal employment in a strip club, and being the victim of sex trafficking. OCDSS failed to address these concerns or coordinate an appropriate response to the allegations, thus failing to assess safety completely.

Was the decision to close the case appropriate?	No
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:

While the mother was not an alleged victim, she was a minor at the time of the report. There were multiple concerns disclosed by the MGF for the mother's mental health, drug use, potential illegal employment in a strip club, and being the victim of sex trafficking. OCDSS did not address the concerns identified or make a new report to the SCR identifying the SM as a maltreated child.

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: 05/04/2020 **Time of Death:** Unknown

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: 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	No Role	Male	5 Day(s)
Deceased Child's Household	Mother	No Role	Female	17 Year(s)
Deceased Child's Household	Other Adult - Mother's friend	No Role	Female	23 Year(s)
Deceased Child's Household	Other Adult - Uncle of Mother's friend	No Role	Male	31 Year(s)
Deceased Child's Household	Other Child - Child of mother's friend	No Role	Female	3 Year(s)
Deceased Child's Household	Other Child - Child of mother's friend	No Role	Male	1 Year(s)
Other Household 1	Other Adult - Father to other children in report	No Role	Male	24 Year(s)

LDSS Response

OCDSS received an SCR report on 4/30/20 regarding the child being born with a positive toxicology. OCDSS was informed that the mother had discharged herself against medical advice and that the SC was remaining in the NICU due to pulmonary complications.

OCDSS made initial contact with the mother by phone. The mother admitted to regular marijuana use throughout her pregnancy to deal with symptoms of nausea. The mother disclosed that the BF had been incarcerated in Florida prior to her moving back to NY from living with her father in Florida. The mother identified having CPS history as a child in Florida.

OCDSS met with the SM in person following the death of the child. The mother no longer wished to speak with OCDSS due to the death of the child and accepted information on services in relation to the death of the child. OCDSS offered services to the mother in relation to the passing of the child and made a referral to a Safe Harbor program on her behalf.

The MGF flew to New York from Florida and spoke with OCDSS. The MGF disclosed multiple concerns for the mother including being a victim of sex trafficking, prostituting herself, working in a strip club as a minor, drug use in the home the mother was living in, a history of self-harm, and ungovernable behaviors. The MGF identified significant history with CPS in Florida and disclosed that he has had the mother hospitalized against her will in the past. The MGF alleged the mother was under investigation as part of a sex trafficking and prostitution ring in Florida, which was why she fled the state and moved back to New York where she had maternal family. OCDSS informed the MGF that he could express his concerns to the Safe Harbor program, however, the program would not be able to discuss anything with him without permission from the mother.

OCDSS interviewed the mother's friend (OA) with whom she was living with. The OA attempted to dismiss concerns for the mother's relationship with an older male that lived in the home and stated they were just friends. The OA stated that the male had children of his own that visited the home. The OA had two children, aged 3 and 1 year old, that were assessed to be safe in her care during the investigation.

OCDSS was informed by hospital staff that thechild had passed away on 5/4/20. OCDSS closed the investigation without taking further action concerning the disclosures made regarding sex trafficking of the mother. OCDSS failed to gather all demographic information for household members, including mother's alleged paramour after having direct contact with him during a home visit and speaking to him by phone. OCDSS failed to speak with a biological father of the other children named in the report despite adding him to the case. There is also no documentation a NOE was provided to the father.

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? Yes
Comments: Onondaga County has an OCFS approved child fatality review team.

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?	☒	☐	☐	☐
Was there an adequate 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?	☐	☐	☒	☐

Explain:
As there was no SCR report surrounding the fatality, OCDSS inquired of relevant collaterals and family members as to whether there was reasonable cause to suspect abuse or maltreatment with respect to the SC's death. OCDSS found there to be no such reason. This was done within 24 hours, 7 days, and upon closure of the report.

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	☒	☐	☐	☐

Explain:
While the SM was not an alleged victim, she was a minor at the time of the report. There were multiple concerns

disclosed by the PGM for the mother's mental health, drug use, potential illegal employment in a strip club, and being the victim of sex trafficking. OCDSS failed to address these concerns or coordinate an appropriate response to the allegations, thus failing to assess risk and service needs completely. A referral was made on behalf of the mother to a safe harbor program.

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? 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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
Services were offered and a referral was made on the mother's behalf to a Safe Harbor program. It is unknown if the mother engaged in services.

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? 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)	Allegation Outcome	Compliance Issue(s)
04/30/2020	Deceased Child, Male, 5 Days	Mother, Female, 17 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
Onondaga County Department of Social Services received an SCR report on 4/30/20 alleging that the mother, aged 17, gave birth to a baby boy on 4/29/20. The baby was born with a positive toxicology for marijuana. The child was born premature at 27 weeks gestation and was transferred to the NICU for pulmonary complications. The baby was expected to remain hospitalized for the foreseeable future.

Report Determination: Unfounded | **Date of Determination:** 05/13/2020

Basis for Determination:
OCDSS initiated their investigation upon receipt of the report. The child passed away due to the medical complications

present at birth on 5/4/2020. OCDSS was informed of no correlation between the child's positive toxicology and the medical concerns presented as a result of the premature birth.

OCFS Review Results:
There were multiple concerns identified for the BM, a minor, being a victim of sex trafficking, having untreated mental health issues, using illicit drugs, and prostituting herself. OCDSS made a referral to Safe harbor on behalf of the mother, however never reviewed the allegations with her directly. OCDSS became aware that the maternal parents were aware of the concerns for the mother and failed to intervene or make an SCR report on behalf of the mother. OCDSS did not contact the biological father of the other children named in the report despite adding him to the case record.

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

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
The investigation was allegation focused despite significant disclosures of concerns for the mother being a victim of sex trafficking and drug use.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
When new concerns are uncovered during the course of the investigation, OCDSS will address all concerns to the standards of all OCFS regulations and requirements.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Two children were named as members of the household. OCDSS added the BF of these children to the report and documented no attempts to interview him regarding the allegations in the report and the alleged drug use disclosed from collateral contacts.
Legal Reference:
432.1 (o)
Action:
OCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
There were missed opportunities to gather collateral information, such as failing to review CPS records from Florida, failing to contact Florida LE in regards to the mother, and contacting the BF of the other children named in the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety all parties named in the report.

Issue:
Failure to offer services
Summary:

OCDSS was informed that the mother may be a victim of sex trafficking and conducted a sex trafficking screening that scored high for being at risk. OCDSS did not discuss the concerns with the mother or attempt to offer additional services.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

A referral was made to a Safe Harbor program on behalf of the mother without having spoken to her about the service. It is unknown if the mother engaged in services after the investigation was closed. Based on the investigation and evaluation conducted, OCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Issue:

Required reports to the SCR/additional information helpful during investigation.

Summary:

Multiple concerns were reported to OCDSS regarding the 17-year-old mother. OCDSS did not make an SCR report against the potential subjects responsible for the care of a minor child that was potentially the victim of child sex trafficking.

Legal Reference:

SSL 422.3

Action:

OCDSS will make a report to the SCR when new concerns of maltreatment or abuse of a child are disclosed to them.

[redacted]

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

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

Known CPS History Outside of NYS

There was reported CPS history regarding the mother as a child in Florida. There is no CPS history for the mother as a parent.

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