Child Fatality Report

Report Identification Number: SY-18-015

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

Issue Date: Jun 08, 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		

Case Information

Report Type: Child Deceased
Age: 0 day(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 04/15/2018
Initial Date OCFS Notified: 04/15/2018

Presenting Information

On 4/15/2018, an SCR report alleged SM had dangerously high blood pressure during her pregnancy, and since 4/4/2018, hospital staff had been telling SM she needed to be induced. Prior to the SC's birth, SM refused all medical treatment including an at-home nurse. On the date of the report, SM awoke from a nap and found herself giving birth to the SC. The SM contacted 911, and upon arrival to the home, EMS found the SC had a weak pulse. EMS intubated the SC and performed chest compressions, and then the SC and SM were taken to the hospital, where the SC was pronounced dead. SC died of cardiac arrest; the cause was unknown. The BF's role was unknown.

Executive Summary

On 4/15/2018, Onondaga County Department of Social Services (OCDSS) responded to an SCR report concerning the death of a female infant (SC). The SC was born at home and died shortly after delivery. The report alleged the infant's mother (SM) was responsible for the death because she did not follow medical advice during her pregnancy.

Within the first 24 hours of the report, OCDSS learned the SC had no siblings, and there were no other children in the home. The SM lived at home with her parents, her adult sibling, and the SC's BF. The family was interviewed on 4/16/2018 and discussed the events leading up to the fatality. OCDSS also spoke with EMS first responders and obtained medical documentation.

On 4/15/2018, SM awoke from a nap feeling like she was about to give birth. The delivery began, and the MGF called 911. Paramedics arrived within 20 minutes of the call, and discovered the baby had been born. EMS found the SC had a weak pulse. EMS initiated CPR, intubated the SC, and transported her and SM to the hospital. Life-saving efforts were continued at the hospital, but were unsuccessful. The SC was pronounced deceased by an Emergency Department physician, and the diagnosis was noted as cardiac arrest. The exact etiology of the cardiac arrest was unknown, though documents noted it may have been respiratory secondary to meconium aspiration. The ME was contacted and relayed he would have only conducted an autopsy without consent if the SM's toxicology screen was positive, because there was otherwise no neglect suspected with regard to the death. The SM's toxicology screen came back negative, and the family declined an autopsy.

LE was informed about the report in compliance with Multi-Disciplinary Team protocols, though they relayed to OCDSS there would be no criminal investigation due to the absence of evidence of foul play.

Medical documentation noted that at the end of her pregnancy, multiple healthcare providers attempted to communicate the urgency to SM that she should obtain treatment for a medical condition and schedule to induce labor. SM was repeatedly made aware of the serious risk her medical condition posed to both her and the unborn child, though she was not willing to comply with the recommendations. The possibility was suggested that the SC died as a result of SM's refusal to follow medical advice at the end of her pregnancy, though according to the CPS Manual, in utero actions or inactions, even if a child is born with complications, does not in and of itself support a determination that the child was abused or maltreated. In such instances, CPS has the responsibility to also consider whether the actions during pregnancy created risk for the parent's ability to care for the child. OCDSS fulfilled such responsibility by gathering evidence to conclude the contrary. The adults in the home responded appropriately by calling 911 once delivery of the SC had begun, and SM did not refuse medical treatment once the SC was born. OCDSS found no evidence of abuse or maltreatment based on actions or inactions of the SM from the time the SC was born to the time of her death. For these reasons, OCDSS

appropriately unsubstantiated all allegations. OCDSS offered appropriate services to all family members and closed the case.

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

Explain:
The determination was appropriate and well-supported in documentation after a sufficient amount of information was gathered. The safety assessments and recorded decisions were appropriate given the circumstances, though they were not required as there were no surviving children.

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:
Casework activity was commensurate with case circumstances, and the decision to close the case was appropriate.

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: 04/15/2018 **Time of Death:** 04:27 PM

Time of fatal incident, if different than time of death: 03:21 PM

County where fatality incident occurred: Onondaga

Was 911 or local emergency number called? Yes
Time of Call: 03:05 PM
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: Post-delivery

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	Aunt/Uncle	No Role	Male	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	0 Day(s)
Deceased Child's Household	Father	No Role	Male	16 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	48 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	52 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)

LDSS Response

OCDSS responded to the SCR report on the date it was received by calling the source, speaking with medical providers, and relaying pertinent information to LE and the District Attorney. On 4/16/2018, LE informed OCDSS they would not be investigating the fatality due to there being no evidence of foul play at that time. LE explained that the ME would notify them if such concern arose after an autopsy, at which point they would have commenced an investigation.

OCDSS interviewed the family members in their home on 4/16/2018. Observations were documented that there were adequate provisions for the SC if she were to have returned home after birth. The family openly discussed the SM's medical condition, and how at her last prenatal appointment, SM was told doctors needed to monitor her and the baby and possibly induce labor. SM reported she had discharged herself from her last appointment at the hospital against medical advice. MGM stated she had urged SM to stay in the hospital but was not able to convince her. OCDSS obtained medical records which showed between 4/3/2018 and 4/13/2018, several different medical providers repeatedly attempted to relay the urgency that SM come to the hospital for treatment due to the medical concerns. SM had been made aware of the serious risk involved to both her and the unborn child. OCDSS spoke with a public health nurse who had been assigned to work with SM in January 2018, and noted the nurse's efforts to engage the SM had been unsuccessful.

SM told OCDSS she awoke from a nap in the afternoon on 4/15/2018 feeling like she needed to have a bowel movement. She stated she knew the baby was coming, so MGF called 911 at 3:05 PM. The family reported the SC's head was coming

out between the time the call was made and the time paramedics arrived. OCDSS received records from EMS which noted upon their arrival at 3:21 PM, SM reportedly did not know if the baby had come out yet. EMS noticed a bulge in SM's shorts and took them off, finding the SC had been born. They noted the SC was not breathing, but a faint pulse was felt. EMS continued chest compressions and intubated SC, then transported her to the hospital. Records noted SC was given no medications prior to arrival at the hospital. Emergency Department staff continued efforts to resuscitate the SC, but were unsuccessful. The SC was pronounced deceased at 4:27 PM.

A toxicology screen was conducted for SM at the hospital, with a negative result for all substances. OCDSS interviewed all family members with regard to general questions about safety and risk to children, and no concerns arose. OCDSS offered grief services and information on financial assistance with burial costs.

OCDSS consulted LE as to whether there was any criminal concern with respect to the ages of the parents (16 and 18 years old), and it was confirmed no charges existed in the present circumstances.

OCDSS thoughtfully considered the facts of the case and their relation to the circumstances of the fatality. OCDSS concluded there was no abuse or maltreatment of the SC by any caregiver after the time she was born. There was no credible evidence that parental actions or inactions contributed to the SC's death.

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 investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The fatality had not yet been reviewed by the Onondaga County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046272 - Deceased Child, Female, 0 Days	046273 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
046272 - Deceased Child, Female, 0 Days	046273 - Mother, Female, 18 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?	☐	☒	☐	☐

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:
Bereavement services and financial assistance for funeral arrangements were offered to the family. It may have been beneficial to offer community-based family planning services to educate the parents about prenatal care and how health conditions could impact the health of a future child.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered, but it was not evident that any services were sought while the investigation was open.

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? 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

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

The SM had never been the subject of a prior CPS report. The SC had no CPS history as she died moments after her birth.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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