Child Fatality Report

Report Identification Number: SY-18-049

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

Issue Date: May 15, 2019

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Oneida
Gender: Female
Date of Death: 11/09/2018
Initial Date OCFS Notified: 11/16/2018

Presenting Information

An SCR report stated the 3-year-old child was born with a heart abnormality which required reconstructive heart surgery at birth. On 11/9/18 at 9:30AM, the mother called into the hospital switchboard and said her daughter was not breathing. The mother was informed to hang up and immediately call 911. At 9:51AM the mother entered the hospital with the child; she had no pulse and was not breathing. The child was resuscitated back to life. At 2PM, the child was transferred to another hospital for a higher level of care. While en route, the child arrested and again when she got to the pediatric intensive care unit. A bedside test was completed and showed a decline in health. On 11/9/18, the mother and father chose to end life support.

Executive Summary

This fatality report concerns the death of a 3-year-old child that occurred on 11/9/18. A report was made to the SCR on 11/15/18, with concerns the parents failed to comply with medical treatment for their child. The child had heart complications, respiratory issues, had been ill the 2 days prior to her death and the parents failed to seek medical treatment. There was an 11-year-old surviving sibling.

Oneida County Department of Social Services (OCDSS) coordinated efforts with law enforcement upon receipt of the report and notified the medical examiner and district attorney. The medical examiner's office informed OCDSS an autopsy would not be performed and they would sign the death certificate only. The mother told OCDSS she signed for an autopsy to be performed and believed one had been completed. It was unclear as to why an autopsy was not performed. OCDSS requested records from the medical examiner's office, but records were not documented to have been received at the time of this writing.

On 11/9/18, the 3-year-old child walked into the common room of the home and collapsed; her breathing was labored. The mother brought the child to the hospital and said she did not know why she did not call 911, she just wanted to get the child to the hospital. Upon arrival at the hospital, the child was not breathing and was transported via ambulance to another hospital. Test results at the hospital showed the child was severely dehydrated and had multiple organ failure. Upon arrival at the second hospital, the parents chose to end life support after a bed-side test showed poor cardiac output.

The child had cardiac issues from birth which required surgery at 10 months of age. Per hospital staff, the parents were noncompliant with the child's medical treatment for at least the last couple of years.

OCDSS completed home visits, interviewed the parents, surviving sibling, the mother's former foster mother, and collateral contacts such as law enforcement and hospital staff. OCDSS had requested all medical records and records from the medical examiner's office; at the time of this writing, the record did not reflect this documentation had been received.

OCDSS offered the family grief counseling and burial assistance; it is unknown if the family utilized these services. OCDSS completed required reports and safety assessments accurately and on time. The case remained open at the time of this writing.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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 remains open.

Required Actions Related to the Fatality

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

Issue:	Review of CPS History
Summary:	The SCR fatality report was received by OCDSS on 11/15/18 and they did not review the family's history until 11/21/18.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	Within 1 business day of a report, OCDSS must review all SCR records of prior reports, including legally sealed reports, involving the subject of the report, the allegedly abused or maltreated child, or the child's sibling, and, for indicated reports, must also review prior reports pertaining to other children in the household or other persons named in the report, and document such.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/09/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 09:30 AM

County where fatality incident occurred: Oneida

Was 911 or local emergency number called? Unknown
Did EMS 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: walking

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	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)

LDSS Response

The SCR report was received by OCDSS on 11/15/18. On this same date, OCDSS initiated their investigation and coordinated efforts with LE. An initial home visit was attempted but unsuccessful.

The CW called the mother who said she and her daughter (the 11-year-old surviving sibling) would be staying at her former foster mother's home for the night. The mother agreed to meet with the CW the following day. The CW received a call from the former foster mother to confirm the sibling was staying with her, the sibling was safe, and that she had no concerns of domestic violence or substance abuse by the parents.

On 11/16/18, the CW and LE completed a home visit with the family. The CW gave condolences to all family members and provided the parents with information regarding grief counseling and burial assistance. The mother disclosed that when she was 8 months pregnant, the doctor discovered the child had a heart problem. The father said the doctor found 2 holes in her heart and her heart was not pumping blood through her body properly. The parents said when she was 10 months old, she had surgery to repair 1 of the holes and the doctor said the other one did not need to be fixed at that time and would be fixed when she turned 5 or 6 years old. The parents said the child also required an oxygen tank due to breathing issues and would occasionally require a nebulizer.

The mother said that on 11/9/18 around 9:30AM, the child walked out of her room and collapsed in the common area of the apartment- her breathing was labored. It's unknown where the father was at the time. The mother said the child had collapsed in the past (details unknown). The mother said she took the child to the hospital in her friend's car. She was not sure why she did not call 911, she said she just wanted to get the child to the hospital. Upon arrival at the hospital, medical staff wanted the child to be transported to another hospital via helicopter but the weather prohibited that from happening.

The mother said the child had not been feeling well on 11/7/18 and only wanted milk, and the mother did say the child was urinating every couple of hours. The mother signed releases and said the child was seen in October 2018 by her pediatric cardiologist.

The sibling was interviewed and said she was at school when the incident happened. The sibling denied the adults abused drugs or alcohol and she said they did not engage in domestic violence. The CW offered the sibling counseling and she said she was interested.

The CW called the nurse manager who worked for the hospital where the child was brought initially. She said the child arrived around 9:51AM not breathing and the mother told her the child had not had a wet diaper for 3 days. The nurse manager spoke with the cardiologist who said the mother was not compliant with medical treatment, no-showed for several appointments, and he had not seen the child in 2 years. The mother also told another doctor at the hospital the child had not had a wet diaper for 3 days. Test results at the hospital showed the child was severely dehydrated and had multiple organ failure. When the CW asked the mother about this, the mother said the child was drinking milk and urinating regularly.

The case record did not reflect the child's cardiologist was interviewed. Requests for medical records were made, but the record did not show they were received. The record did not reflect if the lack of medical treatment contributed to the child's death. It was unknown if a law enforcement investigation was pending.

The CW spoke with the ME's office and was informed an autopsy was not and would not be performed and they would sign a death certificate only. The CW asked the mother about this and she claimed she signed paperwork for autopsy to be completed and that one was completed. The CW requested records from the ME's office. It was unclear why an autopsy was not performed.

The case remained open at the time of this writing.

Official Manner and Cause of Death

Official Manner: Unknown
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
049761 - Deceased Child, Female, 3 Yrs	049763 - Father, Male, 30 Year(s)	Inadequate Guardianship	Pending
049761 - Deceased Child, Female, 3 Yrs	049763 - Father, Male, 30 Year(s)	DOA / Fatality	Pending
049761 - Deceased Child, Female, 3 Yrs	049763 - Father, Male, 30 Year(s)	Lack of Medical Care	Pending

049761 - Deceased Child, Female, 3 Yrs	049762 - Mother, Female, 28 Year(s)	DOA / Fatality	Pending
049761 - Deceased Child, Female, 3 Yrs	049762 - Mother, Female, 28 Year(s)	Lack of Medical Care	Pending
049761 - Deceased Child, Female, 3 Yrs	049762 - Mother, Female, 28 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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?	☐	☐	☒	☐

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? 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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Unable to Determine
Explain:
Services were offered to the family but it was unknown if they utilized them.

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 to the family but it was unknown if they utilized them.

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? Yes

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

From 2009-2010, there were 2 unfounded reports against the mother for Inadequate Guardianship of the SS.
2015-unfounded report against the mother's former foster mother for Inadequate Guardianship of the SS.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

Preventive Services History

12/1/07-3/31/09 a preventive services case was opened for the mother as she had been recently discharged from foster care and had a newborn child (the SS). The mother and SS were placed in a facility which helped mothers who wanted to live independently after leaving care. The mother received education, daycare, and employment services through the facility. The mother was supposed to be working or going to school and attend bimonthly meetings; however, the mother was noncompliant. The mother did have a parent aide from a local agency, and her services case was closed.

4/1/09-12/9/09 a preventive services was opened to assist the mother with re-enrollment into a GED program and obtain daycare. The case was closed due to the mother's noncompliance and the mother having her foster parents as a support.

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