NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-15-006 **Prepared by: Rochester Regional Office**

Issue Date: 7/29/2015

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: 0 day(s)
Jurisdiction: Chemung
Gender: Male
Date of Death: 02/10/2015
Initial Date OCFS Notified: 02/11/2015

Presenting Information

Yesterday 2/10/15 the BM gave birth to the SC while at home. The BM knew the SC was in distress and intentionally let the baby die on the bathroom floor because she did not want the baby.

Executive Summary

Chemung County Department of Social Services received an SCR report on 2/11/15 with allegations of IG and DOA/Fatality regarding the SC; the subject of the report was the BM, the BF, MGP's, MA, and the MU were listed as no role. On 2/10/15 the BM gave birth to the SC while at home with no medical assistance. Although the SC was in distress the BM allowed the SC to die before going to the hospital. The BM lived with the MGP's, a 12 year-old MA, and a 9 year-old MU.

According to the preliminary autopsy the cause and manner are pending further investigation.

The BM reported that on 2/11/15 around 4:00am she started to feel contractions and she went to the bathroom and gave birth to the SC. The BM then cleaned the SC and cut the umbilical cord the BM stated the SC was breathing spastically. The BM took a 30 minute shower after showering the BM stated the SC was no longer breathing. She then wrapped the SC in a blanket, cleaned the bathroom and her clothing placed the SC in a shoe box and took a nap. The BM stated that she hid her pregnancy from her family, but she received pre-natal care. Her plan was to give the SC up for adoption. The BM called the clinic around 9:00 am to report that she had given birth to a stillborn child; she was instructed to take the SC to the emergency room. The BM arrived at the hospital at approximately 10:00 am. Staff at the hospital did not believe the SC had been stillborn, based on the coloring of the SC, and called the police.

There is no CPS history on the BM there is CPS history regarding the BF as a minor.

The SCR report of 2/11/15 was indicated and closed on 4/17/15 there are no surviving siblings. There are no criminal charges.

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?** Yes
- **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Casework Activity was commensurate with case circumstances.

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:
Decision to close 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: 02/10/2015 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: CHEMUNG
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: birth

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	Aunt/Uncle	No Role	Female	12 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	9 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	0 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	52 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	54 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Other Household 1	Father	No Role	Male	20 Year(s)

LDSS Response

CCDSS received an SCR report on 2/11/15 with allegations of IG and DOA/Fatality regarding the SC; the subject of the report was the BM, the BF, MGP's, a MA and a MU listed as no role. On 2/10/15 the BM gave birth to the SC while at home with no medical assistance. Although the SC was in distress the BM allowed the SC to die before going to the hospital. The BM lived with the MGP's, a 12 year-old MA, and a 9 year-old MU.

CCDSS conducted a joint investigation with local police. The BM did not disclose to her family that she was pregnant. The BM told the BF about the pregnancy and she was receiving pre-natal care. Her plan was to give the SC up for adoption but the BF wanted to raise the SC with the help of his family. During the initial interview, the BM reported that she taken herbal supplements in an effort to have a miscarriage. The BM reported that on 2/10/15 around 4:00am she started to feel contractions and she went to the bathroom and gave birth to the SC. The BM then cleaned the SC and cut the umbilical cord the BM stated the SC was breathing was labored. The BM took about a 30 minute shower after showering the BM stated the SC was no longer breathing. She then wrapped the SC in a blanket, cleaned the bathroom and her clothing placed the SC in a shoe box and took a nap. The BM stated that she did not seek medical assistance because she wanted the SC to die. The BM called the clinic around 9:00 am to report that she had given birth to a stillborn child; she was instructed to take the SC to the emergency room. Before the BM left for the hospital she had breakfast with her family, she did not disclose she had given birth. The BM arrived at the hospital at approximately 10:00 am. Staff at the hospital did not believe the SC had been stillborn, based on the coloring of the SC, and called the police.

CCDSS interviewed the MGPs. The MGPs were aware that the BM has been dating the BF, but they were not agreement with the relationship. The family home schooled the MA and the MU and when interviewed they did not know the BM had been pregnant. The family was offered services, but declined. The MGPs reported they would seek therapy through their Church.

The BF was interviewed by CCDSS who reported that he was out of town when the SC was born. The BF stated that the morning of the SC's birth the BM texted him a picture of the SC and told him the SC was still born, but had no further contact with the BM. He was unaware of how exactly the SC died. According to the BF he and the BM met with the MGF the Sunday before the SC's birth. The BF stated he thought at that meeting he and the BM were going to tell the MGF about the pregnancy. Instead at the meeting the BF was told to stay away from the BM. The BF was living with his

grandparents and he was looking for work and he wanted to raise the SC. The BF reported that he had engaged in weekly therapy to assist with the loss of the SC and he was in need of no other services.

Currently there are no criminal charges against the BM but there could be pending the issuance of the final autopsy report. CCDSS conducted a thorough investigation of the allegations. Services were offered to the BM, BF and MGPs; all declined services and were engaged in therapy. The SCR of 2/11/15 was indicated and closed on 4/17/15.

Official Manner and Cause of Death

Official Manner: Pending
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
017561 - Deceased Child, Male, 0 Days	017566 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
017561 - Deceased Child, Male, 0 Days	017566 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated

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 safety 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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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? Yes
Explain:
The family was offered services but declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM and BF were offered grief counseling service and declined.

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

CCDSS received SCR reports on 10/2/2003, 3/6/06, 6/20/06, 7/6/06, 5/15/07, 9/24/07, 10/26/07, 11/3/08, 3/22/08, 4/30/09, 10/29/09, 9/10/10, 11/27/10, 6/11/11, 7/28/11 and 10/23/12 with allegations of IG, PD/AM, LS, IF/C/S, EdN and MN regarding the BF, 3 PA's and 1 PU. The subjects of the reports were the PGF and PGM.

In each event, CCDSS conducted an assessment of immediate danger to the surviving brother in the report within 24 hours, completed safety and risk assessments, implemented safety plans when needed, gathered sufficient information to make determinations for all allegations of abuse and maltreatment. CCDSS offered multiple services for the family.

The SCR reports of 10/23/03, 3/6/06, 5/15/07, 3/22/08 and 4/30/09 were IND and closed on 12/23/03, 7/11/06, 11/19/07, 6/2/08 and 11/24/09 respectively. The SCR reports of 6/20/06, 7/06/06, 9/24/07, 11/3/08, 10/29/09, 6/11/11, 7/28/11 and 10/23/11 were UNF and closed on 9/18/08, 9/18/06, 3/17/08, 3/17/08, 2/20/09, 11/24/09, 7/6/11, 1/4/12 and 1/4/12 respectfully and the SCR reports of 9/10/10, and 11/27/10 were tracked as a FAR case and closed on 3/4/11 and 3/4/11.

The specific information concerning these investigations is not relevant to the circumstances concerning the subject child's death or the assessment of the adequacy of the districts investigation of the current fatality.

Known CPS History Outside of NYS

There is no history of CPS 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