Child Fatality Report

Report Identification Number: SY-22-036

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

Issue Date: Jan 05, 2023

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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 1 month(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 07/15/2022
Initial Date OCFS Notified: 07/15/2022

Presenting Information

Onondaga County Department of Children and Family Services notified OCFS of the death of the 1-year-old subject child via a 7065 Agency Reporting Form. The child passed away during an open CPS investigation that began on 5/30/22. Onondaga County Department of Children and Family Services documented the child was diagnosed with cardiomyopathy with arrythmia on 6/7/22 while in the Neonatal Intensive Care Unit. The child passed away in the hospital on 7/15/22.

Executive Summary

This fatality report concerns the death of the 1-month-old that occurred on 7/15/22. The child died during an open investigation concerning the mother's positive toxicology for both prescription and illicit drugs at the time of the child's birth. There were also concerns for the mother's untreated mental health disorders. The child remained in the hospital for the entirety of her life. There was a 9-year-old sibling who was in the care and custody of the maternal grandmother. The sibling was assessed to be safe.

Onondaga County Department of Children and Family Services (OCDCFS) gathered information from the hospital that the child was born at 33 weeks gestation. The child was diagnosed with cardiomyopathy and her condition was not improving. As a result of the child's heart condition, she passed away. An autopsy was not performed. OCDCFS obtained the death certificate which listed the immediate cause of death as heart failure due to or as a consequence of genetic cardiomyopathy gene and/or non-compaction cardiomyopathy. The manner of death was natural.

Prior to the child's death, the mother was arrested for violating an order of protection regarding an individual in the community. As a result, the mother was incarcerated. OCDCFS filed a Neglect Petition in family court against the mother on behalf of the child. OCDCFS identified that the mother was unable to plan for the child. A temporary order of custody was granted, and the grandmother became the child's custodian. The Neglect Petition was withdrawn as the child's demise was inevitable.

The family was offered bereavement services and burial assistance. It was unknown if the services were utilized. The investigation remained open at the time this report was written.

PIP Requirement

OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS will review the plan and revise as needed to address ongoing concerns.

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:
Safety Assessments were not required as the death was not reported to the SCR.

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:
Casework activity was commensurate with case circumstances regarding a non-SCR reported fatality.

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: 07/15/2022 **Time of Death:** 06:00 AM

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: Hospitalized

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	Female	1 Month(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)

LDSS Response

On 5/30/22, OCDCFS began their investigation into an SCR report regarding the mother's drug misuse and untreated mental health concerns. Despite the mother's positive toxicology, the mother denied using any drugs other than marijuana. OCDCFS completed a Plan of Safe Care with the mother and observed the child in the hospital.

Prior to the death, OCDCFS learned from hospital staff that the child was not doing well due to a heart condition that was being monitored by hospital doctors. Hospital staff reported that the child showed symptoms of failure to thrive, which could have been a result of the medications prescribed to the mother or due to the mother's recreational drug use. The child's health continued to deteriorate, and she was not feeding normally. Hospital staff reported the family would need to decide to have the child relocated to another hospital for a heart transplant or to discontinue medical treatment. On 7/7/22, the child was transported to another hospital to be reviewed for a heart transplant; however, the child passed away prior to the heart transplant operation.

After learning of the child's death from hospital staff, the safety of the sibling was assessed at the grandmother's house. The sibling did not reveal concerns for his safety. The grandmother was offered bereavement services for her and the sibling. The mother was offered services; however, she remained incarcerated, and it was unknown if she was able to receive the services.

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 referred to an OCFS approved Child Fatality Review Team? Yes

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?	☐	☐	☒	☐

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:
A Risk Assessment Profile was not required as the death was not reported to the SCR.

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?	☐	☒	☐	☐
Explain as necessary: The sibling did not need to be removed as a result of the death.				

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? Yes
Explain:
The sibling was offered bereavement services. It remained unknown if the sibling attended counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was offered bereavement services and burial assistance; however, it remained unknown if the mother utilized the services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
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

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ Had heavy alcohol use
☐ Smoked tobacco
☒ Used illicit drugs
☐ Used prescription drugs
☐ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

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)
05/30/2022	Deceased Child, Female, 3 Days	Mother, Female, 30 Years	Inadequate Guardianship	Pending	Yes
	Deceased Child, Female, 3 Days	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Pending	

Report Summary:
An SCR report alleged that during the weekend of 5/27/22- 5/29/22, the mother tested positive for cocaine,

benzodiazepines, and marijuana while giving birth to the subject child. The child did not test positive for drugs and was healthy. There was no Plan of Safe Care in place and the mother had suicidal ideation. The mother attempted suicide on 5/24/22. The mother had mental health disorder diagnoses. As a result, the child was in imminent danger of harm.

Report Determination: Undetermined

OCFS Review Results:
The investigation was initiated timely, and the source of the report was contacted. Home visits were made, and collaterals were contacted. Family members were interviewed. Written notice of the SCR report was not provided to the mother. A Plan of Safe Care was put into place by OCDCFS. The investigation remained open at the time this report was written.

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

Issue:
Failure to provide notice of report

Summary:
Although written notice of the report was provided to the father and grandfather, the record did not reflect the mother was provided with written notice.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
OCDCFS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first 7 days following the receipt of the report.

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

5/15/13- 7/25/13 The mother was unsubstantiated for IG and IF/C/S of the sibling.

1/28/15- 3/26/15 FAR There were reported concerns regarding the LS and LMC against the MGF regarding the sibling.

7/22/16- 9/29/16 The mother was substantiated for IG regarding the sibling.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

Preventive Services History

7/9/13- 10/30/13- A services case was opened as the mother required assistance in obtaining temporary assistance and food stamps. The mother required assistance in locating and securing a home for herself and the sibling and learning how to independently care for the sibling without the assistance of the grandparents. The mother was offered casework counseling and mental health services; however, the mother was noncompliant with OCDCFS and the services providers and therefore, the case was closed.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/11/2022	There was not a fact finding	There was not a disposition
Respondent:	062102 Mother Female 30 Year(s)	
Comments:	OCDCFS filed a Neglect Petition against the mother as the mother had untreated mental health disorders, engaged in criminal activity, and was unable to care for the child as she was incarcerated. OCDCFS withdrew the petition on 7/15/22 as the child passed away.	

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