NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-15-033 **Prepared by: Spring Valley Regional Office**

Issue Date: 4/25/2016

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	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-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 Still Born
Age: Unknown
Jurisdiction: Ulster
Gender: Unknown
Date of Death: Unknown
Initial Date OCFS Notified: 07/07/2015

Presenting Information

"On 7-6-2015 at 10:45pm, EMS and police responded to father's 911 call. About 10 minutes after their arrival, the mother gave birth to a baby boy in the motel room where parents are currently living. When EMS delivered the baby boy he was covered in feces, and they started CPR. The mother and baby boy were transported by ambulance to the hospital. The babyboy was pronounced dead. Both parents have a history of heroin misuse. The mother is a recovering addict and has used during her pregnancy"

Executive Summary

On 7/7/15, Ulster County Department of Social Services (UCDSS) conducted an investigation into the allegations of DOA/Fatality, Parent's Drug/Alcohol Misuse, and Inadequate Guardianship against the mother and father on behalf of the subject child. UCDSS coordinated their investigation with the local police department. The investigation included a historical check, criminal background search, and interviews with collateral contacts and relevant family members.

During the investigation, the mother reported she was in her third trimester and received regular prenatal care. A C-section to deliver the subject child was scheduled for 7/24/15. The mother reported that she was not taking any medication during her pregnancy besides pre-natal vitamins. The mother reported that she had one year of sobriety and was receiving case management services. The mother stated that on 7/6/15, she felt the need to push and felt the baby's head. The mother stated that she told the father to call 911 and EMT arrived and delivered the subject child on the bed. The mother stated that the subject child was covered in feces and was not breathing. The subject child was taken to the hospital and pronounced deceased.

Face to face visits occurred with the parents at their home, however the father was not interviewed about the allegations or circumstances related to the subject child's death. The progress notes did not provide details of the parent's ability to care for the subject child, or indicate if the parents had any provisions available for the subject child's arrival. UCDSS conducted a home visit to the paternal aunt's (pa) home where the sibling had been residing prior to the subject child's death. The sibling resided with the PA due to the parents' drug misuse and incarcerations. UCDSS learned that the sibling was doing well, played sports, attended therapy and did not have any special needs. Contact between the parents and the sibling was minimal. Appropriate collateral contacts were made and external documentation was included in the case record. The safety assessments were completed timely, incorporated relevant information and were detailed. The risk assessment did not accurately reflect the unstable housing conditions for the parents. The progress notes were well documented and contemporaneous. Supervisory consultations were detailed in the progress notes.

On 7/21/15, UCDSS received the autopsy report. The subject child was stillborn and the cause of death was "Intra-Uterine Fetal Demise Associated with Maternal Drug (Heroin) Use". On 9/2/15, UCDSS appropriately unsubstantiated the allegations against the parents and closed the case with no services. The determination was made within the required sixty-day mandate.

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:
UCDSS completed a full investigation of the allegations of DOA/ PD/AM, and IG and appropriately unfounded and closed the investigation.

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:
The investigation was appropriately closed within 60 days.

Required Actions Related to the Fatality

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

Issue:	Face-to-Face Interview (Subject/Family)
Summary:	Face to Face visits occurred with the father/subject at the case address, however the father was not interviewed about the allegations or circumstances related to the subject child's death.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	All subjects of the SCR report must be interviewed.

Fatality-Related Information and Investigative Activities

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Minute(s)

Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	40 Year(s)
Other Household 1	Sibling	No Role	Male	9 Year(s)

LDSS Response

On 7/7/15, Ulster County Department of Social Services (UCDSS) conducted an investigation into the allegations on the report. UCDSS coordinated their investigation with the local police department. The investigation included a historical check, criminal background search, and interviews with collateral contacts and relevant family members.

During UCDSS's investigation, appropriate collateral contacts were made and pertinent information was obtained. Upon receipt of the report, a supervisory consult was conducted and details were documented. The mother reported to UCDSS that she was receiving long term case management and she had one year of sobriety. The mother indicated that she received regular prenatal care and a C-section to deliver the subject child was scheduled for 7/24/15. The mother reported that she was not taking any medication during her pregnancy besides pre-natal vitamins. The mother stated that on 7/6/15, she felt the need to push and felt the baby's head. The mother stated that she told the father to call 911 and EMT delivered the subject child on the bed. The mother stated that the subject child was covered in feces and was not breathing. The subject child was taken to the hospital and pronounced deceased. The father was not interviewed about any of the allegations. UCDSS conducted a home visit to the paternal aunt's (PA) home where the sibling had been residing prior to the subject child's death. The sibling resided with the PA due to the parent's drug misuse and incarcerations. The sibling was the only child residing in the PA's home. UCDSS learned that the sibling was healthy, played sports, attended therapy and did not have any special needs. The PA stated that she believed the mother completed drug rehabilitation and the father recently was in drug rehab. The PA stated that a couple of weeks before the subject child's death, the mother looked pale and lifeless. The mother told the PA that nothing was wrong when she offered to take her to the hospital.

UCDSS' safety assessments accurately reflected the case circumstances and were timely. The risk assessment did not reflect the documented unstable housing conditions for the parents. The progress notes were well documented and contemporaneous. The surviving sibling's safety with the paternal aunt was appropriately assessed and the surviving sibling was receiving community based services.

On 7/21/15, UCDSS received the autopsy report. The cause of death was "Intra-Uterine Fetal Demise Associated with Maternal Drug (Heroin) Use. The autopsy also detailed a well-developed infant consistent with 37 weeks of gestation without congenital abnormalities. On 9/2/15, UCDSS appropriately unsubstantiated the allegations against the parents and closed the case with no services required. The determination was made within the required sixty-day mandate.

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: N/A

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
024421 - Deceased Child, Male, 1 Minute(s)	024422 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
024421 - Deceased Child, Male, 1 Minute(s)	024423 - Father, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
024421 - Deceased Child, Male, 1 Minute(s)	024422 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
024421 - Deceased Child, Male, 1 Minute(s)	024422 - Mother, Female, 40 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
024421 - Deceased Child, Male, 1 Minute(s)	024423 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
024421 - Deceased Child, Male, 1 Minute(s)	024423 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The surviving sibling was residing with the paternal aunt for two years before the fatality.

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	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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary:							

Sevice needs were not documented in the progress notes. Bereavement and/or funeral service needs were not documented. Services for the mother and father were not documented as being offered.

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? No
Explain:
The sibling attended weekly therapy in the community while residing with the paternal aunt.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There are no surviving siblings or other children in the care of the mother and father.

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/11/2013	7104 - Sibling, Male, 7 Years	7101 - Mother, Female, 38 Years	Lack of Supervision	Indicated	Yes
	7104 - Sibling, Male, 7 Years	7105 - Father, Male, 33 Years	Inadequate Guardianship	Indicated	
	7104 - Sibling, Male, 7 Years	7105 - Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Indicated	
	7104 - Sibling, Male, 7 Years	7101 - Mother, Female, 38 Years	Inadequate Guardianship	Indicated	
	7104 - Sibling, Male, 7 Years	7105 - Father, Male, 33 Years	Lack of Supervision	Indicated	
	7104 - Sibling, Male, 7 Years	7101 - Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:
The narrative stated "mother and father are heroin addicts and when they are together, they shoot up heroin in the home around their son and they fall asleep leaving their son unattended. Now that the father is incarcerated, the mother brings other people in the home to shoot up heroin while the child is at home".

Determination: Indicated | **Date of Determination:** 11/25/2013

Basis for Determination:
UCDSS unsubstantiated the allegations of IG, PD/AM, and LS regarding the father due to the father being incarcerated and not having contact with the family in a few years. The allegation of LS was unfounded for the mother because the sibling was in the care of the PA. The allegations of IG and PD/AM was substantiated against the mother because she admitted to smoking marijuana and tested positive for opiates on a drug test. The mother admitted to taking a Vicodin for knee pain that was not prescribed for her use.

OCFS Review Results:
UCDSS' investigation included home visits, contact with the source & collaterals, interviews with the subjects and the

sibling. The safety assessments included relevant information and were completed accurately. The RAP did not incorporate that the sibling was in the care the paternal aunt (PA). The RAP did not identify the secondary caretaker which was the PA. All allegations were appropriately unsubstantiated against the father. The allegation of LS was appropriately unsubstantiated against the mother because the sibling was in the care of the PA. The allegations of PD/AM and IG were inappropriately substantiated against the mother. The case was appropriately closed.

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

Issue:

Appropriateness of allegation determination

Summary:

The allegation of PD/AM was substantiated based soley on the mother's admission to using preschription medication that was not prescribed to her. The sibling was not residing with the mother at the time of her drug use. The allegation of PD/AM should have been unsubstantiated.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(c)

Action:

see summary.

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

An SCR report was received on 8/22/11 with the mother and father listed as the subjects on behalf of the sibling. The reports alleged that the parents have substance abuse history and were still using drugs while caring for the 5 year old sibling. The report alleged that as forms of discipline, the father hit the sibling across the buttocks with a belt and smacked him in the head, and both parents made the sibling eat his meals in his bedroom. The parents were not supposed to be living together but the father regularly resided/stays at the mother’s home. Based on information gathered during the investigation, the allegations of Excessive Corporal Punishment, Parent’s Drug/Alcohol Misuse, and Inadequate Guardianship against the parents were unsubstantiated and the case was unfounded and closed on 9/27/11 with no services required.

The mother became known to the SCR on 1/3/2007. The subjects of these reports were the mother and father. The maltreated child was the sibling. The report alleged that the mother used the 5 month old sibling in an attempt to smuggle contraband in the form of tobacco into the jail where his father was incarcerated. The tobacco was placed in plastic and put in the sibling’s waist band. On 2/8/2007, the allegation of inadequate guardianship was indicated against the mother and father on behalf of the sibling . Visitation to the jail was discontinued for the mother and father. There was no documented service needs.

Known CPS History Outside of NYS

There is no known CPS history 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