Child Fatality Report

Report Identification Number: BU-17-036

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

Issue Date: May 29, 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 Not Found
Age: Unknown
Jurisdiction: Cattaraugus
Gender: Unknown
Date of Death: Unknown
Initial Date OCFS Notified: 12/19/2017

Presenting Information

In June 2013, SM gave birth to an unknown baby at home. SM did not know she was pregnant, but did miss her period in November 2012. The SC would have been almost 30 weeks gestation when it was born. After giving birth on the bathroom floor, SM put the baby in the garbage can and never reported it to anyone. SM did not look at the baby and could not say if the SC was a boy or a girl. SM had a flat affect and no other details were known.

Executive Summary

On 12/19/2017, the Cattaraugus County Department of Social Services (CCDSS) received an SCR report regarding the death of the unknown newborn SC.

On 12/19/2017, SM entered the hospital 31 weeks pregnant and in early labor with her current child (SS). While divulging her medical history, SM stated in June 2013 she did not know she was pregnant and gave birth to the SC in the bathroom of her parents' home. The SC was born deceased so she placed the body in a garbage bag and disposed of the bag in the garbage can outside. SM did not tell anyone about the incident until she recently told her partner (the BF of her current child) after he disclosed he lost an infant in the past.

The incident was investigated jointly with the Wellsville Police Department. SM provided inconsistencies about the incident and was unable to provide any additional details, such as the sex of the baby. SM resided with the MGM, MGF, 17 yo MA and the 14 yo MU at the time of the incident. SM provided no explanation as to why she did not seek assistance from family members that were home when she reportedly gave birth, or why she never sought medical attention in the 12 hours she was in labor. The MGM, MGF and the alleged BF of the SC had no knowledge of SM being pregnant at that time or of the incident.

During the investigation, concerns arose for SM’s MH and her ability to care for the SS. The SS was born during the investigation and CCDSS assessed his safety in a timely manner, although did not complete a 7-day safety assessment in Connections. Upon discharge from the hospital a safety plan was initiated that SM would be supervised with SS. The PGM later applied for and was awarded Article 6 custody of the SS when the safety plan was not being followed.

CCDSS thoroughly investigated the incident and accurately completed the 24-hour and 30-day Fatality Reports, although they were completed late. LE suspected SM fabricated SC being stillborn to bond with her partner over both having infants that died. LE closed their investigation with no criminal charges filed. CCDSS unsubstantiated the allegations against SM as there was no evidence gathered to support that a child was born to SM in 2013, therefore they concluded there was no fatality. CCDSS referred SM for a psychological evaluation, which was completed during the investigation. CCDSS opened a Preventive Services case to provide any recommended services. The Preventive Services case remained open at the time this report was written.

PIP Requirement

CCDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the CCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, CCDSS 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?** 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 decision to unfound the allegations and open the case for Preventive Services was appropriate.

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.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7 day safety assessment was due by 12/26/2017 and there was no assessment completed in Connections.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	CCDSS will complete all safety assessments within regulatory required timeframes.
Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour Fatality Report was due by 12/20/2017 and was not completed until 1/25/2018.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	A 24-hour Fatality Report is required to be completed in Connections within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.

Summary:	The 30-day Fatality Report was due by 1/18/2018 and was not completed until 1/25/2018.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The 30-day Fatality Report is required to be completed in Connections within 30 days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The MA and MU resided in the home and the MU was reported to be home at the time the incident occurred. No attempts were made to interview them as collaterals.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	CCDSS will make diligent efforts to contact all necessary collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Fatality-Related Information and Investigative Activities

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Male	14 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	17 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Unknown	
Deceased Child's Household	Grandparent	No Role	Female	41 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Father	No Role	Male	23 Year(s)

LDSS Response

CCDSS began their investigation on 12/19/2017 by contacting the source, reviewing SCR history, and the Erie County Department of Social Service met with SM at the hospital. CCDSS and LE met with the hospital social worker and learned SM had a flat affect when she disclosed the details of the incident while giving her medical history.

SM was 23 years old and was residing at her parents' home in 2013. SM reported she had her last period in November 2012 and had taken several negative pregnancy tests. In June 2013, SM was assisting with moving heavy bales of hay when she felt a pain in her abdomen. According to SM, her stomach began to hurt and she didn't realize she was in labor until her water broke. SM was unaware she was pregnant and denied showing any physical signs of pregnancy. SM "panicked," not seeking medical assistance or asking anyone for help. Labor lasted 12 hours and during that time she kept using the bathroom directly behind where the MGP were sitting and watching TV. The baby was born in the toilet and she took it out, without noticing the sex. She knew the baby was dead because she had never felt it move. The baby weighed an estimated 6-7 pounds and was pale. She did not check for a pulse or do anything to resuscitate the baby. After she delivered the placenta, she placed the baby in a garbage bag and put the bag in the garbage can outside. SM denied anyone was aware of the incident and she never told anyone until she told her partner. Her partner disclosed his infant son passed away so she felt they had both gone through something similar.

The alleged BF of the SC said he broke up with SM in the Spring of 2013 and they had limited contact since then. He denied any knowledge of SM being pregnant at that time or of any pregnancy scares. He found it hard to believe that SM had a baby without her family knowing; she was always a “tiny thing” and never gained any weight. The MGP denied any knowledge of SM being pregnant in 2013 or of the incident. Considering SM's appearance during her pregnancy with SS, who only weighed 3 pounds, MGM believed there was no way SM could have hidden a pregnancy until she delivered a 6-7 pound baby. The MGP denied that it was possible for SM to deliver the baby in the bathroom while they watched TV in the living room due to the proximity. No attempts were made to interview the MA and MU. SM's partner said SM told him she was 19 at the time, on her own and didn't know what to do.

LE determined there were many inconsistencies in SM’s account of the incident and she was lacking in details. They felt SM fabricated the story to have something in common with her partner. LE closed their investigation with no criminal charges filed.

SM gave birth to a baby boy on 12/23/2017 at 31 weeks gestation; he weighed 3 pounds and remained in the Neonatal Intensive Care Unit for a period. When CCDSS learned of his birth on 12/26/2017, they went to the hospital to assess his safety and the home was later assessed to be safe. Due to concerns for SM’s MH, she was referred for a psychological evaluation. A safety plan was initiated that SM’s partner and the PGM would supervise SM with SS. When SM’s partner did not follow the safety plan, PGM applied for and was granted Article 6 custody. PGM agreed to continue to supervise any contact between SM and SS.

CCDSS conducted a thorough investigation into the alleged incident. They contacted the necessary collaterals including LE, hospital staff, family members, SM’s doctor and Georgia CPS. The partner’s infant’s death was adequately investigated by CCDSS and was determined to have occurred in Georgia in 2012 and was ruled accidental. The allegations were appropriately unsubstantiated against SM as there was a lack of credible evidence to support the SC ever existed. Service needs were adequately assessed and the case was opened for Preventive Services.

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: Cattaraugus County has no OCFS approved Child Fatality Review Team

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046278 - Deceased Child, UNK,	046279 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
046278 - Deceased Child, UNK,	046279 - Mother, Female, 23 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?	☒	☐	☐	☐

Additional information:
The MA and MU were not interviewed and were residing in the home at the time of the alleged incident. MU was reported to be home at the time of the incident.

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?	☒	☐	☐	☐

Explain:
There were no surviving children at the time the report was received on 12/19/2017, therefore a 24-hour safety assessment was not required. The SS was born 12/23/2017 and although he was assessed to be safe on 12/26/2017, the 7-day safety assessment was due by 12/26/2017 and there was none completed in Connections. The 30-day safety assessment was due by 1/18/2018 and was not completed until 1/25/2018.

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?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/16/2018	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	None	
Comments:	PGM applied for Article 6 Custody of the SS on 3/16/2018 and was granted temporary custody.	

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: SM and her partner may have benefited from parenting skills services.							

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:
A safety plan was initiated the SS would be supervised with the SM. The PGM later obtained Article 6 custody of the SS after the safety plan was not followed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
CCDSS offered bereavement services to SM and referred her for a psychological evaluation.

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

An SCR report dated 11/4/2011 with allegations of IG and L/B/W against MGM and MGF regarding MA was tracked FAR.

An SCR report dated 12/19/2011 was substantiated for the allegations of IG and PD/AM against MGF regarding MA and MU and unsubstantiated for the allegation IG against MGM regarding MA and MU.

Known CPS History Outside of NYS

There is 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