Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-20-010

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

Issue Date: Oct 30, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 8 year(s)
Jurisdiction: Chemung
Gender: Female
Date of Death: 06/22/2020
Initial Date OCFS Notified: 06/22/2020

Presenting Information

An SCR report alleged the 8-year-old female subject child fell unresponsive on 6/22/2020 while the father changed her diaper. The parents called 911 and the child was transported to the hospital where she passed away after going into cardiac arrest. The child had a history of cardiac issues and seizures, but the cause of death was unknown when she died. The child had bruising to her arms, legs and neck, and a pinhole-sized mark to her neck, possibly from a needle. The child was immobile and bedridden and would not be able to sustain the injuries on her own. The child had abnormalities to her genitals. It was described as a widening of her vaginal area. The child's death was deemed suspicious as there was not a plausible explanation for the injuries and her medical conditions could not be determined as the sole contributor of the child's death. The parents and the home nurse were named as subjects of the report.

Executive Summary

This fatality report concerns the death of the 8-year-old female subject child that occurred on 6/22/2020. The child was born with medical complications which resulted in her being nonverbal and had limited mobility. At the time of the child's death, she had bruises and injuries that were considered suspicious. Prior to her death, the child resided with her parents and was under the care of an in-home nurse. There were no other children who resided in the home, and the child had no siblings.

Chemung County Department of Social Services (CCDSS) coordinated investigative efforts with law enforcement immediately upon learning of the death. Law enforcement did not find evidence the death was suspicious or criminal in nature and closed their investigation with no charges filed. An autopsy was performed, and the cause of death was ascribed to complications of a large bowel obstruction due to fecal impaction. The manner of death was natural.

The mother explained the days prior to the child's death, she had been vomiting. On the day before her death, the mother worked and arrived home after 3:30 AM. She noticed the child did not look right and appeared thinner with her face sunken in and her eyes bulging. The mother noticed the child was cold and covered her with a blanket. The child started to fall asleep, so the mother left the room to allow the child to rest. The mother planned to call the pediatrician in the morning. Around 7:00 AM, the father picked the child up and noticed she had again vomited. He brought the child to the bathroom to be bathed and the child was unresponsive. Her eyes rolled back in her head and she did not have a pulse. The mother called 911 and performed CPR until EMS arrived and transported the child to the hospital where she was pronounced deceased.

The home nurse was not present at the time of the fatal incident but reported the child's vitals were normal when he left the home the night prior. He noted the child appeared cranky but did not show signs of illness or discomfort.

CCDSS interviewed all subjects of the SCR report; however, the record did not reflect the home nurse was interviewed face-to-face. Additionally, although the caseworker met with the father in the home, the record did not reflect a discussion with the father regarding the allegations. CCDSS completed the required reports and Risk Assessment Profile timely and accurately. Furthermore, CCDSS offered the parents bereavement services in response to the fatality. CCDSS appropriately unsubstantiated the allegations of Inadequate Guardianship, Lacerations/Bruises/Welts and DOA/Fatality against the parents and home nurse. The investigation revealed the child died of natural causes and the death was not a result of abuse or maltreatment by the caregivers.

PIP Requirement
CCDSS will submit a PIP to the Rochester Regional Office within 30 days of the 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?** 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
A Safety Assessment was not due at the time of determination as there were no surviving siblings or other children.

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 decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Although the father was seen, details of the interview with the father were not documented.
Legal Reference:	432.1 (o)
Action:	Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, which may include, but are not limited to, facilitating information gathering and analysis of safety and risk factors, and determining the allegations. CCDSS will address all allegations with each subject and/or parent and document the information appropriately in Connections.
Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:	Although interviewed by phone, the record did not reflect the nurse was interviewed face-to-face. Additionally, the nurse was not noted to have been interviewed about all aspects of the SCR narrative.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/22/2020 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 03:45 AM

County where fatality incident occurred: Chemung
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
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

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☒ Impaired by disability
- ☒ Other: Cognitively Delayed

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	8 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

Other Household 1	Other Adult - Visiting Nurse	Alleged Perpetrator	Male	58 Year(s)

LDSS Response

On 6/22/2020, CCDSS received the report from the SCR and coordinated investigative efforts with LE. A CPS history check was completed and CCDSS began gathering information surrounding the death from LE and the ME.

On 6/22/2020, LE said the SC was dead prior to 7:00 AM and that the SC had pre-existing medical conditions. LE believed the bruising on the SC was consistent with medical intervention. LE noted the SM came home from work around 4:00 AM, felt the SC was cold and put a blanket on her prior to the SC becoming unresponsive. The ME confirmed the SC had congenital medical problems and it remained unknown if the SC had the ability to express pain or discomfort. The ME was told the parents woke to find the SC was limp, unresponsive, and bloated. The parents were unable to describe what happened between 3:45 AM and when 911 was called. The ME said the parents tried to wake the SC around 7:00 AM for a bath and her condition was worsened. 911 was contacted and the SM performed CPR until first responders arrived and took over resuscitation efforts.

On 6/23/2020, CCDSS spoke with the home nurse over the phone. The nurse cared for the SC for a few months and the parents were not very involved with her care. The nurse reported on occasion, he arrived at the home and the SC's diaper had not been changed and she had not been cared for appropriately. He stated he believed the parents neglected the SC's needs. On the evening prior to the death, the SC was in his care until 8:00 PM. During his time with the SC, he said her vitals were normal, yet she appeared cranky. The SC did not vomit while she was in the nurse's care. At 7:00 AM on 6/22/2020, the nurse received a call from the SF informing him the parents were taking the SC to the hospital; when he arrived around 7:45 AM, the SC had been declared deceased.

On 6/23/2020, CCDSS spoke to the SM over the phone. The SM reported she arrived home from work around 3:30 AM on 6/22/2020 and the SF told her the SC was awake. The SM checked on the SC and saw the SC was playing on the floor and that she did not look right. There was vomit on the floor and the SC had been vomiting in the days prior. The SC started to fall asleep, so the SM left her to rest. The SM tickled the SC's feet as she left the room and there was no reaction, which was abnormal. She planned to call the doctor in the morning. Around 7:00 AM, the SF picked the SC up and saw she vomited again. The SF went to bathe the SC and she became unresponsive. The SM called 911.

CCDSS gathered information from first responders, including the fire department. When the fire department arrived, a fireman saw the SC on the bathroom floor and the SM was performing CPR. The SC did not have a pulse and as the fireman prepared to take over resuscitation efforts, the SC took a breath and had a brown substance coming from her nose. The AED was attached, and no shock was advised. The fireman began chest compressions until EMS responded and transported the SC to the hospital.

CCDSS gathered information from hospital staff who believed the parents cared for the SC to the best of their abilities. CCDSS gathered additional information from the employer of the home nurse. It was believed the parents would not intentionally hurt the SC, but their ability to care for the SC's needs was low and the parents required frequent coaching. The employer of the home nurse reported the SC did not have unexplained bruises and it was not believed the parents were neglectful but were unable to fully understand the SC's medical needs.

On 7/7/2020, a home visit was conducted and CCDSS met with the parents. Although the SF was part of the discussion, the record did not reflect details of the conversation relating to the allegations of the SCR report. The parents were accepting of the bereavement referral provided to them and noted they have a strong support system. CCDSS appropriately determined the allegations of the report and closed their case timely.

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: 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
Comments: The death was referred to an OCFS-approved Child Fatality Review Team during the course of the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055187 - Deceased Child, Female, 8 Yrs	055188 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055188 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055188 - Mother, Female, 33 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055189 - Father, Male, 39 Year(s)	DOA / Fatality	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055189 - Father, Male, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055189 - Father, Male, 39 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055190 - Other Adult - Visiting Nurse, Male, 58 Year(s)	DOA / Fatality	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055190 - Other Adult - Visiting Nurse, Male, 58 Year(s)	Inadequate Guardianship	Unsubstantiated
055187 - Deceased Child, Female, 8 Yrs	055190 - Other Adult - Visiting Nurse, Male, 58 Year(s)	Lacerations / Bruises / Welts	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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents were receptive to grief counseling. It remained unknown if the parents engaged in counseling in response to the fatality. The case record noted the parents had a strong support system consisting of family, friends and church members.

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? N/A
Explain:
The child did not have siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The case was referred to the Child Advocacy Center and the parents were provided with a grief counseling referral.

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? N/A
Was the child acutely ill during the two weeks before death? No

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

04/16/2012- 11/01/2012 An SCR report was unfounded against the parents for Inadequate Guardianship and Malnutrition/Failure to Thrive regarding the child.

12/07/2015- 02/01/2016- An SCR report was unfounded against the parents for Inadequate Guardianship, Lack of Medical Care and Lack of Supervision regarding the child.

04/19/2016- 07/01/2016 An SCR report was unfounded against the parents for Inadequate Guardianship and Lack of Medical Care regarding the child.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

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