Child Fatality Report

Report Identification Number: AL-17-018

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

Issue Date: Nov 03, 2017

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 Deceased
Age: 2 year(s)
Jurisdiction: Columbia
Gender: Female
Date of Death: 04/03/2017
Initial Date OCFS Notified: 05/31/2017

Presenting Information

The 2-year-old SC died while there was an open Family Assessment Response (FAR) case with the family. Her death was not reported to the SCR. Columbia County Department of Social Services (CCDSS) became aware of the death and informed OCFS on 4/4/2017 within 24 hours of the fatality.

Executive Summary

The 2-year-old SC passed away while involved in an open FAR case with her BM and MGF with whom she lived. CCDSS was informed about the fatality by LE, who had notified CCDSS as a fellow member of the Columbia County Child Fatality Review Team. CCDSS spoke with LE as well as the family to obtain information about the fatality, and determined there was no reasonable cause to suspect the death was a result of abuse or maltreatment.

Per LE, no autopsy was scheduled to be done at the request of the BM. LE stated their intention was to close their case and note the death was a result of complications from the SC's existing medical conditions. The FAR case record did not reflect whether CCDSS consulted a medical professional as to the cause of death and the death certificate was not obtained; therefore, there the record did not contain documentation of the official cause and manner of death. It was noted the SC had two genetic disorders and required multiple medications and oxygen, and the BM indicated SC had already exceeded the life expectancy of a child with her conditions.

Concerns regarding the adequacy of care provided to the SC and her special needs are what prompted the initiation of the FAR case. CCDSS spoke with the BF prior to the SC's death, and he expressed concerns for the SC's level of care as provided by the BM and MGF. CCDSS confirmed BF had not had contact with the SC in at least a year. CCDSS engaged the BM and MGF throughout the course of their involvement, and found the caregivers were meeting all the SC's regular and special needs, though additional information was not sought from the SC's medical specialist providers when permission by the BM was granted. CCDSS found no information to validate the concerns mentioned in the initial CPS referral.

CCDSS learned the SC had no siblings at the time of her death, and there were no other children living in the home. BM prematurely gave birth to a child five weeks after the SC's death. CCDSS spoke with the BM and learned the SS would remain in the hospital for approximately three more months. CCDSS offered services specific to the fatality, and discussed BM's knowledge of available resources should she need special care for the SS in the future.

CCDSS found there to be no concerns for the SC's care prior to her death, and no concerns were found for the BM's ability to parent when considering the future care of the newborn SS. CCDSS thoroughly discussed the closing of the case with the Department's attorney, supervisor, and the family. After information for voluntary services was provided and circumstances were discussed regarding no CPS concerns or service needs, the appropriate decision was made to close the FAR case.

This review resulted in some citations related to casework practice. In response, CCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days identifying what action they have taken, or will take, to address this. If a PIP is currently in place, CCDSS will review the plan and revise as needed.

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:
Regulatory procedure in Family Assessment Response cases is such that there is no determination of allegations, no determination of the report, and no safety assessment due at the time of the closing of the case.

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:
There was documentation of consultation with supervisors and administrators at pertinent points throughout CCDSS' involvement. The decision to close the FAR case was appropriate given the circumstances.

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: 04/03/2017 **Time of Death:** 10:49 AM

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

County where fatality incident occurred: Columbia
Was 911 or local emergency number called? Yes
Time of Call: 10:25 AM
Did EMS respond to the scene? Yes
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

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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	2 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	73 Year(s)
Deceased Child's Household	Mother	No Role	Female	23 Year(s)
Other Household 1	Father	No Role	Male	22 Year(s)

LDSS Response

CCDSS was involved with the family beginning on 2/16/2017 following a CPS report alleging concerns for the BM and MGF's care of the SC. It was noted the SC had medical conditions and appeared to be at greater risk given her medical issues, age, and developmental level. CCDSS addressed the concerns using the FAR approach. No immediate safety concerns were present within 24 hours of CCDSS addressing the report, nor throughout the duration of their involvement with the SC and her caregivers.

On 4/3/2017, CCDSS was informed of the SC's death by LE. CCDSS learned LE responded as the fatality was considered an unattended death. SC's health conditions were noted, and according to LE, the complications associated with those conditions were considered as having attributed to her death. The SC had no SS and there were no other children in the home, though the BM gave birth to a child after the fatality while the FAR case remained open. The information provided was immediately reviewed between CCDSS supervisors and administrators. Despite learning this information, the SS was never added to the case and though the BM provided the SS's BF's information, there was no effort to contact him or include him in any assessments.

CCDSS learned the sequence of events surrounding the SC's death from LE and the family. CCDSS learned BM placed the SC in her adult bed while she cleaned the crib. The SC fell asleep, and BM briefly left the room. After an unknown amount of time, BM found SC to be unresponsive on the bed. An Early Intervention worker was in the home at the time for a scheduled visit. 911 was called and attempts were made at CPR. Efforts were continued by EMS to no avail, and the SC was pronounced deceased at the home. LE informed CCDSS they planned to consider the death as being a result of complications from the existing medical conditions and close the case with no arrests. The death was not deemed suspicious and no report was made to the SCR. The MGF was home at the time and CCDSS noted that no concerns came of his interview. CCDSS did not question BM and MGF as to whether they were under the influence of drugs or alcohol at the time, though there was no noted concern of this suspicion. CCDSS contacted an Early Intervention worker, but learned it was a different worker who had been in the home at that time; that person was never contacted. CCDSS sought no additional information about the death.

In addition to an Early Intervention worker, CCDSS contacted other collaterals concerning the SC's care prior to her death, including an in-home visiting nurse and the pediatrician. Contact revealed no concerns for the BM's ability to attend to the SC's heightened level of needs, though information was never sought from the specialists, for whom the BM gave permission to contact.

CCDSS learned BM prematurely gave birth to a child following the SC's death, and had not previously been informed of her pregnancy. CCDSS offered services specific to the fatality, as well as to the circumstances of the new child and associated complications. The CW, supervisor, and CPS attorney reviewed the information regarding the new birth and discussed closing the case since no concerns were reported for the new child. Additionally, there were no known concerns regarding the SC's death or the BM's ability to care for children. After a discussion with the BM, the FAR case was closed.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: The fatality has not yet been reviewed by the Columbia County Child Fatality Review Team; however, a review is scheduled.

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Other	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
While some contacts are only required in a CPS investigation, best practice for fatality-related information-gathering includes efforts to gather as much information as possible regarding the facts and circumstances of the death.

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: The sibling was born five weeks after the fatality.				

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? 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 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:
BM stated she had informed her Early Intervention worker of her pregnancy and knew of resources available upon the SS's discharge from the hospital, which was planned to be three months later. Services directly related to the fatality were offered. BM may have benefitted from the suggestion of family planning services surrounding education and healthcare.

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 was born after the fatality, and given the sibling's age, there were no identified needs with respect to the fatality. It was determined the sibling was receiving needed medical services during continued hospitalization.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered to the BM but it was unknown if any were used at the time the case was open. Services were offered, and BM said she planned to use one of them, but it was not evident that any were used prior to case closure.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/16/2017	Deceased Child, Female, 2 Years	Mother, Female, 23 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Female, 2 Years	Grandparent, Male, 73 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 2 Years	Grandparent, Male, 73 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
The SCR report alleged the SC had two medical conditions. The MGF and BM allegedly smoked cigarettes in the home in the SC's presence. It was further noted the BM would leave the SC home alone with the MGF, knowing that he would drink alcohol in combination with pain medication, daily, to the point of intoxication. The BF had an unknown role.

OCFS Review Results:
CCDSS engaged the family in the FAR process and fully addressed the reported concerns and possible risk elements with BM and MGF in the completion of the FLAG over the course of their involvement. BM identified medical specialists who could have provided helpful information about the reported concerns but there was no effort to elicit information from them. CCDSS spoke with some collaterals, but did not speak with the identified BF of the SS who was born after the SC's death nor was he included in the FLAG. The SS was not added to the case although it was noted the intent was for the SS to return to the BM's care following discharge from the hospital. Several notes were non-contemporaneous.

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

Issue:
FAR-Complete Collateral Contacts with Family's Permission
Summary:

There were missed opportunities to gather collateral information, such as the medical specialists who treated the SC. Another important collateral who was not contacted was the BF of the SS who was born after the SC's death and was identified as a parent who planned to be involved in the SS's care.

Legal Reference:

18 NYCRR 432.13 (d)(2)(ii); 18 NYCRR 432.13 (e)(1)

Action:

CCDSS will make diligent efforts to contact collaterals to potentially gather outside information regarding child safety and risk.

Issue:

A child was born during an open CPS investigation and never added to the report

Summary:

The SS was born during this case and was never added to this report.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(e)

Action:

CCDSS is required to obtain the name, age, and condition of other children in the home. CCDSS will add all appropriate household members to open investigations.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Several progress notes were entered non-contemporaneously with their event dates.

Legal Reference:

18 NYCRR 428.5

Action:

All progress notes will be entered contemporaneously to their event dates.

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

Three years prior to the fatality, the SC was not born and there were no siblings known to exist at that time as well.

Known CPS History Outside of NYS

There was no known CPS History outside of New York State.

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.

Casework Contacts

	Yes	No	N/A	Unable to Determine

Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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