Child Fatality Report

Report Identification Number: SV-19-024

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

Issue Date: Jun 26, 2019

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: Dutchess
Gender: Female
Date of Death: 04/08/2019
Initial Date OCFS Notified: 05/29/2019

Presenting Information

Dutchess County Department of Community and Family Services (DCDCFS) learned of the 2-year-old subject child's death on 5/24/19 when contact was made with the child's mother. DCDCFS learned the child passed away on 4/8/19 as a result of her medical condition. While involved with the family in a CPS investigation, DCDCFS was aware the child suffered a medical condition known to cause a short life expectancy.

Executive Summary

This fatality report concerns a 2-year-old female who died during an open CPS investigation. The allegations in that report concerned the child, her siblings, and her parents, but did not relate to the circumstances of the death. There were no safety concerns for the children throughout DCDCFS' involvement prior to the fatality. DCDCFS was informed of the child's death by her mother when phone contact was had on 5/24/19. DCDCFS immediately made the appropriate notifications to the Spring Valley Regional Office in the form and manner prescribed by OCFS.

The child was declared deceased at the hospital after she was transported from her home by ambulance. The death certificate was completed by a hospital physician. An autopsy was not conducted given the circumstance of the child's lifelong illness. The manner of death was deemed natural, and the immediate cause was "respiratory failure, due to or as a consequence of trisomy 18." The child was born with the diagnosis of trisomy 18, also known as Edwards Syndrome. DCDCFS learned from the family, medical staff, and their own research that the condition was a genetic chromosomal disorder often resulting in heart defects and intellectual disabilities, among other symptoms. Inquiries into life expectancy for a child with such condition revealed the majority of infants born with Edwards Syndrome die in the first month of life; the child's pediatrician reported only one percent of these children survive longer than one year, most of whom die of aspiration.

Prior to the child's death, DCDCFS found her parents were adequately meeting her medical needs. The child had a nurse assisting her in the family's home twelve hours a day, seven days a week. The parents were well versed in the child's condition and what to do in the event of an emergency, which was verified following the child's death with the nursing agency's staff and community members who were close to the family. Medical records revealed the child was hospitalized eight times prior to the incident that ended her life. DCDCFS spoke with a member of the local fire department who knew the child and family well; he had responded on each occasion the child was in distress, including the fatal incident. DCDCFS came to learn the mother educated staff at the fire department about her child's condition shortly after her birth, as emergency situations were expected and she felt it important to inform them of her child's needs.

DCDCFS diligently gathered information about the fatality and events leading up to it. It was learned the parents adequately cared for the child and responded appropriately when she was in distress; therefore, it was concluded there was no reason to suspect abuse or maltreatment regarding the death. DCDCFS offered services in response to the family's loss, but they declined, citing their own strong support system in the community. DCDCFS found the surviving siblings, ages 4 and 9, were also well cared for by the parents, finding no safety concerns.

After completing all casework activity – both in regard to the initial allegations and the fatality – and after all appropriate services were offered, DCDCFS documented the conclusion and determination of allegations with respect to the unrelated SCR report that prompted their involvement. There was documentation of supervisory review throughout the case both before and after the fatality, and the final determination for the open investigation was pending supervisory approval; thus,

the case remained open at the time of this writing. Review of DCDCFS' involvement with the family, as well as information-gathering about the fatality, exemplified best casework practice.

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:
There were no fatality-related determinations to be made, as there was no SCR report in response to the fatality. Documentation showed decisions were made surrounding the initially reported allegations and there was evidence in the case which supported this decision; however, the final determination was pending supervisory approval at the time of this writing.

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:
All casework activity was commensurate with case circumstances, and there was evidence of supervisory oversight.

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: 04/08/2019 **Time of Death:** 11:28 PM

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

County where fatality incident occurred: Dutchess

Was 911 or local emergency number called? Yes

Time of Call: 10:28 PM
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: Vomiting

Did child have supervision at time of incident leading to death? Yes
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	Father	No Role	Male	36 Year(s)
Deceased Child's Household	Mother	No Role	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)

LDSS Response

DCDCFS began their involvement with the family in response to an SCR report made on 3/27/19 and found no safety concerns for the three children. The family had no prior CPS involvement, and the allegations in the report did not contain medically-related concerns for the now deceased child; however, DCDCFS learned of her medical condition and at the first home visit, the provision of her medical care was assessed and discussed. DCDCFS found all needs were being met, though they were in the process of gathering supplemental information from collateral contacts. After interviews with the mother and siblings, an observation of the non-verbal subject child and contact with the source of the report, DCDCFS made several attempts to follow up with the family between 4/12/19 and 5/17/19. One week later, successful contact was made with the mother, who shared the family had been busy as the child died on 4/8/19. DCDCFS offered condolences and immediately scheduled a visit to the home that day. DCDCFS promptly began gathering information from other relevant sources about the death of the child.

DCDCFS met with the parents on separate occasions and learned about the time leading up to the child's death. The whole family was home on 4/8/19, and both parents tended to the child when she came to be in distress late in the evening. The child began vomiting; the mother called 911 when she began showing signs of difficulty breathing. As prescribed, the mother administered a treatment from a medical device to assist with breathing. When the treatment did not appear effective, the mother conducted CPR. A member of the fire department was first on scene and began assisting the mother's efforts. DCDCFS spoke with this person, who responded to similar incidents with the child on multiple prior occasions. He and the parents recognized there were observations about the child which appeared different than those previously, inferring an impression there may not be a positive outcome. He noted the mother did everything she could to save her child. The Dutchess County Sheriff's Office, Hyde Park Police Department, and ambulance responded to the home, and

the child was transported to the hospital, where she was declared deceased.

DCDCFS gathered medical records for the child, including all documentation of recent and previous hospitalizations, as well as pediatrician records. Information from the pediatrician noted facts about the child's illness and short life expectancy, and DCDCFS learned the pediatrician had no concerns for the care the parents provided for her and her siblings. DCDCFS spoke with the agency who provided in-home nursing care. They noted having observed that all the children's needs appeared met and the parents were knowledgeable about providing the necessary care and treatment for the child, including emergency interventions. It was reported the parents' knowledge and abilities were comparable to the nurses who tended to her.

DCDCFS spoke with the family and siblings about their loss and grief, and provided verbal and written information on relevant services available in their community. DCDCFS spoke with the person whom the mother identified was a strong support for their family. That person relayed the parents were nurturing and tended to their children's every need, and said she and the community were there to support the family.

DCDCFS exhibited exceptional casework practice by diligently gathering information and engaging the family and collaterals. DCDCFS concluded their involvement with the family at an appropriate time after all activities were completed. Decisions about the determination of allegations reported on 3/27/19 were documented and well-supported.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Dutchess County does not have an OCFS-approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: Many services were offered, though the parents declined. Other than a recommendation for fatality-related services, no service needs were identified during DCDCFS' involvement.				

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	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
Many services were offered to the children, as information was offered to their parents. The parents chose to utilize their own support system.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:

Many services were offered to the parents in response to the fatality. The parents chose to utilize their own support system.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/27/2019	Sibling, Male, 9 Years	Mother, Female, 35 Years	Lack of Medical Care	Pending	Yes
	Sibling, Male, 9 Years	Father, Male, 36 Years	Lack of Medical Care	Pending	
	Deceased Child, Female, 2 Years	Mother, Female, 35 Years	Inadequate Guardianship	Pending	
	Sibling, Female, 4 Years	Mother, Female, 35 Years	Inadequate Guardianship	Pending	
	Sibling, Male, 9 Years	Mother, Female, 35 Years	Inadequate Guardianship	Pending	
	Deceased Child, Female, 2 Years	Father, Male, 36 Years	Inadequate Guardianship	Pending	
	Sibling, Female, 4 Years	Father, Male, 36 Years	Inadequate Guardianship	Pending	
	Sibling, Male, 9 Years	Father, Male, 36 Years	Inadequate Guardianship	Pending	

Report Summary:
An SCR report alleged the mother, father, and three children under age 10 resided with a vicious dog who recently attacked an adult. Despite the risk the dog posed to the children, the parents allowed the dog to remain in the home. Consequently, after the dog attacked the adult, the dog bit the eldest child in the face. The mother and father sought medical treatment for the child, but did not disclose the injury was a result of a dog bite. They failed to previously give the dog a Rabies vaccine and refused to give the bitten child a Tetanus vaccine. It was alleged that as a result, the child was at risk of significant infection and the dog continued to pose imminent risk to the children.

Report Determination: Undetermined

OCFS Review Results:
DCDCFS conducted a thorough investigation into the allegations, supportive to determine there was no concern for inadequate medical care and the dog did not pose significant risk to the children. Though the eldest sibling received a minor injury from the dog, the parents took proper precautions of which the child did not heed; further, the parents

sought prompt medical attention and received appropriate treatment for the injury. DCDCFS gathered sufficient information regarding the fatality which occurred during the open case. All investigative activities were timely and appropriate; however, one citation was noted concerning timely delivery of notification letters.

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

Issue:
Failure to provide notice of report

Summary:
The Notice of Existence letters were not sent to the subject parents until 5/30/19, two months past the required timeframe to provide such written notification.

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

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

[redacted]

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

There is no CPS history more than three years prior to the fatality.

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

Additional Local District Comments

The Dutchess County Department of Community and Family Services continues to work on issuing Notice of Existence letters timely, whether hand delivered or mailed.

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