Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-19-013

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

Issue Date: Sep 16, 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: 8 year(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 04/05/2019
Initial Date OCFS Notified: 04/05/2019

Presenting Information

An SCR report alleged the eight-year-old child died on 4/5/19 while in the care of his maternal grandfather. The grandfather was aware the child needed his tracheostomy tube in and when EMS arrived the child did not have the tube. The child was in distress and initially had a pulse. The child was pronounced dead at the hospital. The grandfather claimed the child was eating a Pop-Tart, but the scene did not indicate that information. Two crack pipes were located in the room where the child had his medical emergency. A subsequent report was received and merged that alleged the grandfather's partner returned home to find the child passed out, gasping for air and vomiting from the nose. She called 911 and his mother. The child suffered from an airway obstruction, which caused a lack of oxygen, leading him to go into cardiac arrest. There were a significant amount of crack pipes found in the home. The grandmother was under the influence as her behavior was erratic and all over the place.

Executive Summary

On 4/5/19, the Albany County Department for Children, Youth and Families (ACDCYF) received an SCR report regarding the death of the eight-year-old male child. The child had multiple surgeries on his throat and had a tracheostomy, but was otherwise healthy.

A joint investigation was conducted by ACDCYF and law enforcement. It was learned the maternal grandfather was caring for the child at the grandfather's home while the mother was at work. When the grandfather checked on the child, he saw that the child had vomited, he was convulsing and his tracheostomy tube had come out. The grandfather and his partner tried to put the tracheostomy tube back in, then the partner called 911 and the mother. While suctioning the child, the fire department found two crack pipes in the child's suction machine. The child was transported to the hospital via ambulance and attempts to resuscitate him were unsuccessful. The child was pronounced deceased by the hospital physician at 1:11 PM.

There were no siblings and no other children resided in the mother's, grandfather's or his partner's homes. The father had no contact with the child, his address was unknown, and ACDCYF made reasonable attempts to locate him and were unsuccessful. ACDCYF assessed the grandfather's and mother's homes and found no safety hazards or drug paraphernalia.

An autopsy was performed and it was determined the child died from an obstruction of airway by granulation tissue polyp arising at internal tracheostomy stoma (a small polyp in the trachea which obstructed the airway). The law enforcement investigation closed with no criminal charges filed.

ACDCYF conducted a thorough investigation and contacted all necessary collaterals. Although the information was gathered timely to complete the 24-hour and 30-day Fatality Summary Reports, these reports were approved late in Connections. The allegation of Inadequate Guardianship was substantiated against the grandfather and his partner for leaving drug paraphernalia accessible to the child.

The allegation of DOA/Fatality against the mother, grandfather and his partner and Inadequate Guardianship against the mother were unsubstantiated as it was determined the child's death was caused by a complication of a pre-existing medical condition and not by the actions or inaction of the adults. The allegation of Parent's Drug/Alcohol Misuse against the grandfather's partner was unsubstantiated as there was a lack of credible evidence that she was under the influence of

drugs or alcohol while being the sole caretaker of the child.

The mother and grandfather were referred for bereavement services, which were declined, and the case was closed as there were no surviving children.

PIP Requirement
OCFS' review resulted in some citations. In response, each cited county will submit a PIP to their Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the respective LDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, the LDSS 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:
Safety assessments were not required as there were no surviving 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 case was appropriately indicated and closed as there were no surviving children.

Required Actions Related to the Fatality

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

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 to be completed and approved by 4/6/19 and was not approved until 4/10/19.
Legal Reference:	CPS Program Manual, Chapter 6, K-1

Action:	The Child Protective Service is required to complete the 24-hour Fatality Report within 24 hours of receipt of a report alleging the death of a child as a result of child 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 to be completed and approved by 5/5/19 and was approved on 5/21/19.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The Child Protective Service is required to complete the 30-Day Fatality Report within 30 days of receipt of a report alleging the death of a child as a result of child abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/05/2019 **Time of Death:** 01:11 PM

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

County where fatality incident occurred: Albany
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? 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
How long before incident was the child last seen by caretaker? 10 Minutes
At time of incident supervisor was: Unknown if they were 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	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Other Household 1	Father	No Role	Male	53 Year(s)

Other Household 2	Grandparent	Alleged Perpetrator	Male	62 Year(s)
Other Household 3	Other Adult - Grandfather's Partner	Alleged Perpetrator	Female	49 Year(s)

LDSS Response

ACDCYF initiated their investigation within 24 hours of receipt of the SCR report. They spoke to law enforcement, hospital staff and the DA's office, and reviewed hospital records of the incident.

ACDCYF spoke to the emergency room physician, the child's pediatrician, and the child's ear, nose and throat specialist and learned the child had a narrowing of his airway from being born prematurely. The child had numerous surgeries to correct the issue and had a tracheotomy procedure in 2018. The child occasionally had a mucous plug that required suctioning and the mother had a machine that was used for this procedure. The mother was meeting the child's medical needs and was well-trained in caring for the child. The child could go into distress very quickly and medical professionals did not know if the grandfather was trained in caring for the child's tracheostomy tube.

ACDCYF met with the mother, grandfather and his partner and conducted home visits at the mother's and grandfather's homes. Through interviews with the three adults, it was learned the grandfather and his partner had babysat the child regularly for 2-3 months while the mother was at work. The mother dropped the child off at the grandfather's home at 9:45 AM on 4/5/19, on her way to work. The child watched TV in a bedroom while the grandfather stayed in the living room and he checked on the child every 5-10 minutes. The grandfather gave him a Pop-Tart to eat, as he often did, and went back into the living room. When the grandfather went into the room to check on the child, he was convulsing, he had vomited and his tracheostomy tube had fallen out. The grandfather's partner was sleeping in another bedroom and had woken up about 12:00 PM. She heard the grandfather yelling and when she entered the bedroom, she saw that the child had passed out. They tried to put the tracheostomy tube back in and the partner called 911, then the mother. The ambulance was at the home when the mother arrived and resuscitation efforts were being performed.

The mother reported she had shown the grandfather and his partner how to care for the child and that the partner worked in healthcare. The grandfather reported he did not need any training on caring for the child's tracheostomy, as the child could clear blockages himself and the mother used the machine. All three adults denied using drugs or alcohol on the day of the incident and denied having any knowledge of how the crack pipes got into the child's machine.

ACDCYF spoke to first responders from the fire department, who confirmed two warm crack pipes were located inside the child's machine during their attempts to suction the child's tracheostomy and that the grandfather appeared to be under the influence. Law enforcement stated that the grandfather smelled of alcohol while at the hospital and hospital staff reported the grandfather's partner appeared to be under the influence.

ACDCYF contacted all necessary collaterals and information gathered supported that the child died from an obstruction of airway due to a pre-existing medical condition. ACDCYF referred the family for bereavement services and appropriately closed the case.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051061 - Deceased Child, Male, 8 Yrs	051065 - Other Adult - Grandfather's Partner, Female, 49 Year(s)	Inadequate Guardianship	Substantiated
051061 - Deceased Child, Male, 8 Yrs	051065 - Other Adult - Grandfather's Partner, Female, 49 Year(s)	DOA / Fatality	Unsubstantiated
051061 - Deceased Child, Male, 8 Yrs	051065 - Other Adult - Grandfather's Partner, Female, 49 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
051061 - Deceased Child, Male, 8 Yrs	051062 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
051061 - Deceased Child, Male, 8 Yrs	051062 - Mother, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
051061 - Deceased Child, Male, 8 Yrs	051064 - Grandparent, Male, 62 Year(s)	Inadequate Guardianship	Substantiated
051061 - Deceased Child, Male, 8 Yrs	051064 - Grandparent, Male, 62 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:

Reasonable attempts were made to locate and interview the father, but were unsuccessful.

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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 adults denied using drugs, although crack pipes were found in the grandfather's home and the family may have benefited from substance abuse services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A

Explain:
The family was referred for bereavement services, which they declined.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/23/2016	Deceased Child, Male, 5 Years	Father, Male, 50 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
Orange County Department of Social Services (OCDSS) received an SCR report that alleged the father sold cocaine from his vehicle while in the presence of the child, who was five-years-old at the time.

Report Determination: Indicated **Date of Determination:** 02/20/2018

Basis for Determination:
The father was visiting with the child and sold cocaine from his vehicle while the child was in the backseat. The father was arrested and incarcerated. The child was in the maternal grandmother's care and the mother resided in Albany County.

OCFS Review Results:
Upon receipt of the report, OCDSS observed the child, briefly spoke to the grandmother, step-grandfather and mother, and interviewed the father in jail. There was no case activity from 5/2/16-11/2/17. Ongoing safety of the child was not assessed during that time and the safety concern of the father's drug sales around the child was not adequately addressed. On 2/16/18, the child was interviewed at school, school staff were spoken to, the grandmother's home was assessed for safety, the grandmother was interviewed and the case was closed. No services were offered as it was reported the father had moved to Albany County and was no longer visiting the child.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
OCDSS did not assess the on-going safety of the child from 5/2/16-11/2/17; there was no casework activity during that time period and the safety concern of the father's drug sales around the child was not adequately addressed.

Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)

Action:
OCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

PIP Requirement:
OCDSS will submit a PIP to the Spring Valley Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS will review the plan and revise as needed to address ongoing concerns.

[redacted]

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

SCR report in Orange County dated 8/22/12 was unsubstantiated for the allegation of Lack of Supervision against the mother of the subject child regarding the father's adult child, who was 15-years-old at the time. The mother was not a person legally responsible for the child at that time.

SCR report in Orange County dated 1/4/12 was unsubstantiated for the allegations of Inadequate Guardianship and Lack of Medical Care against the mother of the subject child regarding the father's adult child, who was 15-years-old at the time, and Inadequate Guardianship against the mother of the subject child regarding the subject child. The mother was following through with the subject child's medical appointments and the father was meeting his other child's needs with the assistance of service providers.

Known CPS History Outside of NYS

There was 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