Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-19-015

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

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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: 22 day(s)
Jurisdiction: Greene
Gender: Female
Date of Death: 05/17/2019
Initial Date OCFS Notified: 05/22/2019

Presenting Information

The prematurely born subject child was hospitalized throughout her short life, and died during an open child protective investigation. An SCR report had been made the day after her birth, alleging concerns against her mother. On her fourth day of life, the infant was transported from Columbia Memorial Hospital to Albany Medical Center's Neonatal Intensive Care Unit (NICU) for a higher level of care, after exhibiting concerning medical symptoms. She was scheduled to remain hospitalized for several weeks. On 5/21/2019, the family's investigative caseworker with Greene County Department of Social Services (GCDSS) contacted the NICU and then the parents; it was then that the father stated the infant passed away, four days prior. After confirming with hospital staff that the death was medically related, GCDSS promptly informed the Albany Regional Office in the form and manner prescribed by OCFS and continued gathering information.

Executive Summary

This report concerns the death of an infant who passed away during an open Child Protective Services investigation. Beginning in April of 2019, GCDSS investigated concerns that the infant was the mother's fifth child, the rest of whom were formerly and permanently removed from her care. After learning of the infant's death during a routine phone call to the father, GCDSS gathered supplemental information from hospital staff to inquire of the circumstances of the fatality.

GCDSS received a written medical summary concerning the child's death. The summary included information about the child's treatment, from admission to death. Hospital staff informed GCDSS the child died as a result of septic shock. This diagnosis was among many others suffered by the child, as was listed in the medical summary. Medical records indicated the parents requested an autopsy, though further information was not noted. Though requested, the child's full medical records had not been received by GCDSS at the time of this writing.

The infant was born on 4/25/2019. Two days later, she was transported to the NICU of a hospital in a neighboring county to better meet her medical needs, as her condition worsened. There, she underwent surgery and was provided with several medical interventions, including medications. On 5/16/2019, the infant vomited and aspirated. It was also discovered on that date she was experiencing septic shock. An exploratory laparotomy was performed, where further medical concerns were made evident. The infant presented with an irregular heartbeat, and was unresponsive to treatment. The next day, when medical interventions were futile to treat what was considered "acute decompensation," life-supporting devices were removed and the child was given end-of-life care in the presence of her parents.

Based on information at their disposal, GCDSS did not find reason to suspect the infant's death was a result of abuse or maltreatment by a caretaker. There were no apparent safety concerns for the child throughout their involvement. There was no need for police involvement or notification; the death did not prompt an SCR report, and the cause was medical in nature.

As part of their investigation, GCDSS gathered facts about the historical parenting concerns for the mother in relation to the allegations in the open investigation and her other four children. GCDSS verified her other children were adopted and resided with their adoptive parents; this placement followed the mother's legal surrender of her parental rights. The subject child's father indicated he had no children aside from the decedent.

GCDSS provided the parents and paternal grandparents with information on bereavement and mental health crisis

services. The parents shared such services were potentially beneficial, but it was unknown if any were utilized. The grandparents were offered services as they identified being the parents' main supports; the parents were also co-located in a residence on their property.

After sufficient information was gathered and documented with respect to the fatality and the open investigation, GCDSS ended their involvement and closed the case.

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:
The fatality was not reported to the SCR; however, all other casework activities and decisions were appropriate and documented in a timely manner.

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, and there was documentation of supervisory consultation throughout the case record.

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: 05/17/2019 **Time of Death:** 10:12 AM

Date of fatal incident, if different than date of death: 05/16/2019

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

County where fatality incident occurred: Albany
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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
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	22 Day(s)
Deceased Child's Household	Father	No Role	Male	27 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)

LDSS Response

On 5/21/2019, GCDSS learned the infant who was reported as an alleged maltreated child one-month prior passed away at the hospital. The infant had been hospitalized the duration of her short life.

Prior to the fatality, GCDSS was investigating the appropriateness of her parents' care, given the mother's significant child protective history. GCDSS had already completed several required investigative tasks, such as interviews with the parents, contact with the hospital providing medical care to the child, contact with relevant collateral contacts, and a home assessment. GCDSS found no safety concerns for the infant, had she been discharged home from the hospital as was initially expected. GCDSS learned from hospital staff that the parents were visiting the child throughout her hospitalization and presented no concerning behaviors. GCDSS was in process of addressing identified areas of risk by offering preventive services and recommending a substance abuse evaluation for the mother. The parents had agreed to such services, but none were initiated following the fatality or prior to the case closing; there were no other children in their care.

GCDSS contacted the father as part of routine follow-up on the aforementioned date. The father informed the child died of septic shock on 5/17/2019. GCDSS offered condolences and extended availability in the event the family had any needs, then contacted hospital staff to gather more information. The father shared they had no needs at the time, though upon subsequent contacts, GCDSS discussed and provided information on services related to grief and mental health.

GCDSS learned from conversations with hospital staff and the accompanying medical records that the child had some

complications during her stay at the NICU, but rapidly declined beginning 5/16/2019. It was noted she experienced "acute respiratory decompensation" following an episode of choking on vomit, resulting in a lung infection. Also of note were heart-related complications, in addition to septic shock from infection. The infant was treated with medications, underwent a procedure, and remained sustained with an intubation device. The parents took the opportunity given to them to hold the child as her vitals declined. The child was given medication to keep her comfortable while she passed away. The doctor who declared the child deceased noted the parents requested an autopsy.

In response to learning of the fatality, GCDSS notified the Albany Regional Office of the death that occurred during their open investigation. The information gathered was sufficient to conclude there was no reasonable cause to suspect parental abuse or maltreatment. GCDSS documented the whereabouts and safety of the surviving half siblings, all of whom were adopted approximately one year prior. After the infant passed away, neither parent had any children in their care. GCDSS completed a thorough investigation into the care and wellbeing of the infant prior to her death. They concluded their involvement at an appropriate time when all necessary information was gathered and services were offered.

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: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Greene 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?	☐	☒	☐	☐

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:
No service needs were identified for the surviving siblings, who resided with their adoptive parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were provided a plethora of information on fatality-related services. The parents identified grief services could have been beneficial, though it was unknown whether any services were utilized while the case was open.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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? Yes
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

- ☒ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☒ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
04/26/2019	Deceased Child, Female, 1 Days	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report alleged the mother gave birth to the subject child the day prior to the report. Of concern was that the mother had four children removed from her care in the past and all had since been adopted. The mother reported the children were no longer in her care due to issues of domestic violence with their father; however, it was noted this was not the same biological father as the newborn. There was allegedly reasonable cause for concern for the newborn's safety. The role of the newborn's biological father was unknown.

Report Determination: Unfounded **Date of Determination:** 06/05/2019

Basis for Determination:
GCDSS promptly and continuously investigated whether there were safety concerns for the infant; none were revealed. After a CPS record check, GCDSS spoke with Schoharie County Department of Social Services, confirming four half siblings were adopted in 2018; the mother previously surrendered her rights. GCDSS spoke with the mother's former treatment providers and learned she had made improvements. A home assessment was completed, and it was observed the parents had appropriate accommodations for the infant's anticipated return home. When GCDSS learned the infant died during the investigation, sufficient information was gathered and documented, and the appropriate services were offered.

OCFS Review Results:
A thorough investigation was completed with regard to the allegations, and sufficient information was gathered

concerning the fatality. GCDSS gathered supportive evidence to determine the child's death was not a result of any caregiver's abuse or maltreatment. Prior to the fatality, GCDSS offered preventive services and a substance abuse evaluation for the mother; this was initially accepted by the parents. After the fatality, such services were deemed unnecessary as the parents no longer had children in their care; however, they were provided information on grief counseling and mental health services in the community, in response to their loss.

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

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

There is no CPS history in New York State for the subject child more than 3 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

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