Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-19-022

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

Issue Date: Dec 11, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 8 year(s)
Jurisdiction: Warren
Gender: Female
Date of Death: 07/14/2019
Initial Date OCFS Notified: 07/15/2019

Presenting Information

An SCR report was received with concerns the 8-year-old child died on 7/14/19 while in the care and supervision of her mother. The cause of death was unknown.

Executive Summary

This fatality report concerns the death of an 8-year-old female subject child (SC) that occurred on 7/14/19. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother (SM). Warren County Department of Social Services (WCDSS) received the report and investigated the child's death. An autopsy was completed, but the official report was not yet available at the time of this writing; however, the medical examiner verbally informed WCDSS the child's cause of death was more than likely endocarditis (infection of the inner lining of the heart).

At the time of the child's death, she resided out of state with her mother and 10-year-old sister (SS). The investigation revealed the family was in New York for the weekend visiting with family and friends and were staying at a hotel. The child had been ill with fever and vomiting prior to the family leaving for New York, and the illness worsened during the afternoon of 7/14/19. On that date, the mother brought the child to an urgent care to be examined. Medical documentation noted the child had been complaining of chest pain, heart and neck pain, nausea, and difficulty breathing. The urgent care physician conducted tests, including an x-ray, and no abnormalities were found. The child was discharged with medications to treat her nausea. It was reported the child's fever broke during the day and she appeared to be feeling better as time went on. Around midnight on that same date, the child awoke to use the bathroom. While walking down the hall, the child collapsed and began seizing. A family friend began CPR while emergency services were called. An ambulance arrived and transported the child to the local hospital. Medical staff attempted resuscitative efforts for one hour to no avail. The child was pronounced deceased at 2:01 AM.

WCDSS exhibited best casework practice throughout this investigation. From the time it began to the time of its closure, WCDSS worked diligently with law enforcement and out of state Child Protective Services to assess the safety of the sibling and gather information surrounding the family and the fatal incident. WCDSS spoke with numerous collateral sources and interviewed the mother and the family friend present on the date of the child's death. There was no evidence that abuse, or maltreatment led to the death of the child; therefore, the allegations were unsubstantiated and WCDSS closed their case.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
    - **Approved Initial Safety Assessment?** Yes

- **Safety assessment due at the time of determination?** Yes

- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

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:
WCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the SS prior to case closure.

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 record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case 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: 07/14/2019 **Time of Death:** 02:01 AM

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

County where fatality incident occurred: Warren
Was 911 or local emergency number called? Yes
Time of Call: 12:57 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: Walking to the restroom.

Did child have supervision at time of incident leading to death? Yes

At time of incident supervisor was:

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

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	46 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)

LDSS Response

On 7/14/19, WCDSS received the SCR report regarding the death of SC, which occurred on that same date. WCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. WCDSS discovered the family was visiting the area for vacation but resided in another state.

On this same date, WCDSS spoke with several sources and confirmed the family had already returned to their home out of state. WCDSS reached out to CPS in that state and arranged for a courtesy visit to assess the safety of the SS as well as observe the home environment.

WCDSS learned from LE that SC was feeling ill prior to leaving their home state for the weekend. Medical records obtained noted SC had been vomiting, had a fever, was lethargic and not eating well. On 7/13/19, SC was brought to an urgent care by SM. SC had been complaining her chest felt heavy, and she had difficulty breathing with pain in her heart and back. Urgent care staff completed a urinalysis and an abdominal x-ray; no concerns were noted. SC was prescribed anti-nausea medication and discharged. The family reported to LE that SC's fever broke later and she appeared to be feeling better. LE informed WCDSS shortly before midnight on 7/13/19, SC got out of bed to use the bathroom and collapsed onto the floor. LE reported when first responders arrived, SC was exhibiting seizure-like behavior, and CPR was administered for one hour before hospital staff declared SC deceased. LE explained medical staff felt the cause of death may have had something to do with a congenital defect.

On 7/15/19, WCDSS received notice from the out of state CPS that contact with the family had been made and there were no concerns surrounding the SS. The CPS worker reported SM and SS were interviewed surrounding the fatality and they had no concerns of any wrong doing, abuse or neglect; the worker would not elaborate further and refused to send WCDSS notes pertaining to the interview. The out of state CPS declined to cooperate with WCDSS further.

On 7/16/19, WCDSS spoke via phone with a family friend who was vacationing with the family when SC died. The friend explained they took a vacation to NY every year with the same group of people; she had no concerns regarding SM or her care of the CHN. The friend explained SC had been sick the whole weekend, and SM took her to the doctor; the doctor

said SC was fine. The friend stated she did not see the events that led to SC collapsing, but she did administer CPR to SC until paramedics arrived. The friend explained she did not know of any past medical concerns regarding SC. She stated the CHN's father was deported several years ago and lived in another country. The friend had no further information.

On 9/10/19, WCDSS spoke with SM via phone. SM reported she was receiving counseling, denied any concerns regarding and reported she was working with DSS in her state for additional services.

Throughout the investigation, WCDSS spoke with numerous collateral sources, including the CHN's pediatrician, the coroner, LE, EMS, and medical staff that treated SC. LE found no criminality regarding SC's death. WCDSS found no evidence to support the allegations received in the report and therefore unfounded and closed the case.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: This fatality investigation was conducted by the Warren County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Warren County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052301 - Deceased Child, Female, 8 Yrs	052302 - Mother, Female, 46 Year(s)	DOA / Fatality	Unsubstantiated
052301 - Deceased Child, Female, 8 Yrs	052302 - Mother, Female, 46 Year(s)	Inadequate Guardianship	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:
WCDSS gathered information from family members and all appropriate collateral sources. Progress notes and all other documentation was entered timely.

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:
SM sought counseling independently to address her grief. CPS in the family's resident state offered additional services.

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?	☐	☒	☐	☐
Explain as necessary: There were no surviving children that were removed as a result of this fatality report.				

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:
WCDSS requested CPS in the family's resident state offer the family with appropriate service referrals. SM was already engaged in individual counseling with an independent provider.

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? Yes
Explain:
Out of state CPS met with the family in their home and discussed services available for the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SM sought out an independent counselor in her community.

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? No
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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