NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: AL-14-033 **Prepared by: Albany Regional Office**

Issue Date: 6/8/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Schenectady
Gender: Male
Date of Death: 12/23/2014
Initial Date OCFS Notified: 12/23/2014

Presenting Information

On December 23, 2014, Schenectady County DSS received an SCR report alleging that the 4-year-old deceased child ingested non-edible objects, and was exhibiting symptoms of diarrhea and vomiting. The parents delayed medical care for the deceased child. On December 23, 2014, the deceased child died. It is unknown if the deceased child ingested something and was otherwise a healthy child. There are surviving siblings with unknown roles, ages 16, 3, and 2 years old.

Executive Summary

On 12/21/14, the deceased child was transported by his parents to Ellis Hospital for symptoms of diarrhea and fever. The deceased child was transferred to Albany Medical Center that same evening for further stabilization and care. The surviving siblings, ages 3 and 2, remained at home in the care of their maternal aunt. The 16-year-old surviving sibling was visiting with a maternal grandmother for the entire weekend.

On 12/23/14, Schenectady County Department of Social Services (SCDSS) immediately initiated the investigation by interviewing and/or observing the mother, father and surviving siblings, ages 16, 3, and 2 years old. SCDSS also interviewed the maternal aunt who was present in the home prior to the deceased child's hospitalization, the deceased child's teacher, law enforcement, and medical providers. SCDSS caseworkers conducted multiple home visits, reviewed medical records for all of the children, assisted the family with obtaining medication for the 16-year-old surviving sibling, ensured that the family obtained ongoing medical care for the younger surviving siblings, and offered the family grief counseling throughout the investigation. The 3-year-old and 2-year-old surviving siblings had exhibited vomiting symptoms within days of the deceased child's hospitalization. The deceased child was diagnosed with medical conditions in 2010 for which regular medical care was being provided. The cause of death was anoxic encephalopathy due to cardiac arrest of unknown cause. The allegations were unsubstantiated due to lack of credible evidence, and the case was closed on 2/20/15.

A second SCR report was made on 2/19/15 again alleging DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care regarding the deceased child and all surviving siblings, ages 16, 3, and 2 years old. SCDSS immediately interviewed and/or observed all parents and surviving siblings. In addition to the above listed activities, the second investigation also included coordination with law enforcement on interviews of family members, and collaboration with child welfare authorities outside of New York State. SCDSS learned new information about the timeline of activities leading to the deceased child's hospitalization and consulted with the medical examiner. Although the medical examiner would not assert that a different timeline may have prevented the deceased child's death, his medical recommendation, based on the child's medical conditions, was that medical evaluation/treatment should have been sought sooner. The parents made continual efforts to obtain regular medical and mental health care for the surviving siblings. All allegations were unsubstantiated except for Lack of Medical Care regarding the deceased child. Upon closure of the investigation, the family agreed to open a Preventive Services case to address ongoing medical care for the surviving siblings, which remains open at this time.

Based on a review of all above investigation activities, there are no required actions warranted. SCDSS investigation activities were in compliance with regulatory standards.

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

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.

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: 12/23/2014 **Time of Death:** 01:45 PM

Date of fatal incident, if different than date of death: 12/21/2014

County where fatality incident occurred: SCHENECTADY
Was 911 or local emergency number called? No
Did EMS to 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
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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

Based on interviews with family members and the deceased child's teacher, caseworkers learned that there had been no changes within the family's routine during the week prior to the deceased child's hospitalization and death. The household of the deceased child included the mother and all surviving siblings. The father did not live with the mother, but otherwise visited the home on a daily basis to have dinner with the family and help the children to bed. The 16-year-old sibling was staying with the maternal grandmother for the weekend and was not home. The deceased child attended school on 12/19/14, where the teacher reported no symptoms of illness, changes in demeanor or energy level, or anything out of the ordinary. On 12/21/14, the 3- and 2-year-old siblings were vomiting during the early morning hours. During that day, the deceased child had diarrhea and fever, for which the mother gave prescribed doses of Children's Motrin and ginger ale. The maternal aunt had come to the mother's home that morning, and remained into the evening to assist with care of all of the children. The father arrived at the mother's home early evening. The parents checked on the deceased child, and decided to transport him directly to Ellis Hospital due to its close proximity. The child was in cardiac arrest upon arrival, and was transferred to Albany Medical Center for further stabilization efforts.

None of the medical doctors interviewed would assert that the deceased child's death could have been prevented had the family sought medical treatment earlier during that day. Caseworkers consulted the medical examiner about the family's reported timeline of events and the child's presentation with fixed and dilated pupils at the hospital. The medical examiner believed that the child's previously diagnosed medical conditions may have contributed to the deceased child experiencing anoxia sooner than someone with an otherwise normal hemoglobin level, and the diagnosis was "anoxic encephalopathy due to cardiac arrest of unknown cause."

Prior to the fatality, the family made regular efforts to seek medical care for the deceased child and surviving siblings. The safety of the surviving siblings was assessed throughout the investigation. Based on the consistent timelines of events

described by family members, combined with the absence of a medical doctor's assertion that the deceased child's death could not have been prevented, all allegations were unsubstantiated. The investigation was closed on 2/20/15.

A second SCR report was made on 2/19/15 alleging that the parents failed to seek medical care for the deceased child to prevent his death, and failed to seek mental health and/or medical care for the 16-, 3- and 2-year-old siblings. Caseworkers interviewed family members and medical providers and verified that the parents made continual efforts to seek mental health and medical care for the surviving siblings. Caseworkers learned new information from the mother and maternal aunt about the deceased child's fever symptoms and care activities prior to his hospitalization on 12/21/14: the deceased child's fever was 103.6° not 101°; only one dose of Children's Motrin and 8 ounces of ginger ale were given; and that the mother would have otherwise brought the children to the hospital for a fever of 102°or higher but didn't feel it was necessary. Although the medical examiner would not assert that the different timeline caused the deceased child's death, he believed that medical evaluation/treatment should have been sought sooner based on the deceased child's previously diagnosed medical conditions. Based on this new information from the family and medical examiner, all allegations were unsubstantiated except for Lack of Medical Care regarding the deceased child. The family agreed to Preventive Services to address ongoing medical care for the surviving siblings, which remain open at this time.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: Undetermined if injury or 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?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
015776 - Deceased Child, Male, 4 Yrs	015777 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
015776 - Deceased Child, Male, 4 Yrs	015777 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
015776 - Deceased Child, Male, 4 Yrs	015777 - Mother, Female, 35 Year(s)	Lack of Medical Care	Unsubstantiated
015776 - Deceased Child, Male, 4 Yrs	015778 - Father, Male, 43 Year(s)	DOA / Fatality	Unsubstantiated
015776 - Deceased Child, Male, 4 Yrs	015778 - Father, Male, 43 Year(s)	Inadequate Guardianship	Unsubstantiated
015776 - Deceased Child, Male, 4 Yrs	015778 - Father, Male, 43 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

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?	☐	☐	☒	☐

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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

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 Unavaliable	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? Yes
Explain:
The younger surviving siblings, ages 3- and 2-years-old, received medical examinations on 12/23/14, and follow up care throughout the investigation. The 16-year-old and 3-year-old surviving siblings participated in grief counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Casework counseling and advocacy for public assistance matters were provided to birth parents. Grief counseling was continually offered and declined by both parents throughout the investigation.

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? No
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)
06/14/2013	2367 - Sibling, Male, 7 Months	2365 - Mother, Female, 34 Years	Lack of Medical Care	Unfounded	No
	2367 - Sibling, Male, 7 Months	2366 - Father, Male, 42 Years	Lack of Medical Care	Unfounded	

Report Summary:
On 6/14/13, an SCR report alleged that the parents failed to fill a prescription, and attend a scheduled follow up medical appointment for, the 2-year-old sibling.

Determination: Unfounded | **Date of Determination:** 08/22/2013

Basis for Determination:
The investigation included interviews with family members, medical providers, review of medical records, and visits to the home. By the time of the caseworker's initial home visit on 6/14/13, the family had already made alternate arrangements to fill the prescription for medication, and to take the 2-year-old sibling for medical evaluation. Based on this information and the parent's consistent attendance to the medical care of all the children in the home throughout the investigation, the allegations were unsubstantiated and the case was closed on 8/22/13.

OCFS Review Results:
There were no identified concerns.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/19/2014	2368 - Deceased Child, Male, 4 Years	2372 - Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	No
	2369 - Sibling, Male, 16 Years	2372 - Mother, Female, 35 Years	Inadequate Guardianship	Unfounded	
	2368 - Deceased Child, Male, 4 Years	2372 - Mother, Female, 35 Years	Lack of Medical Care	Unfounded	
	2369 - Sibling, Male, 16 Years	2372 - Mother, Female, 35 Years	Childs Drug / Alcohol Use	Unfounded	

Report Summary:
On 12/19/14, an SCR report alleged that the 16-year-old sibling used marijuana five times per week, and that the mother was aware but did nothing about it. A second report, on 12/22/14, alleged that deceased child had exhibited diarrhea symptoms for (3) days and the parents failed to seek medical care. This was consolidated with the first report.

Determination: Unfounded | **Date of Determination:** 02/20/2015

Basis for Determination:
The caseworker coordinated with law enforcement, interviewed family members, deceased child's teacher, medical and service providers, reviewed medical records, and visited the home. There was lack of corroboration from family members and collateral contacts about the 16-year-old's drug use or the mother's failure to seek assistance. The deceased child attended school on 12/19/14, where the teacher reported no symptoms of illness, changes in demeanor or energy level, or anything out of the ordinary. The allegations were unsubstantiated, the case was closed on 2/20/15, and Preventive Services were opened 4/01/15.

OCFS Review Results:
There were no identified concerns.

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

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

On 10/25/01, an SCR report alleged Lack of Supervision against the mother and maternal uncle regarding the 16-year-old male sibling; these allegations were substantiated. On 11/23/04, an SCR report alleged Inadequate Guardianship and Lack of Medical Care against the mother regarding the 16-year-old sibling; these allegations were unsubstantiated. On 4/11/05, an SCR report alleged Inadequate Guardianship and Lack of Supervision against the mother regarding the 16-year-old male sibling; these allegations were substantiated. On 11/22/05, an SCR report alleged Inadequate Guardianship against the mother and maternal aunt regarding cousins of the deceased child, ages 3- and less than 1- year old at the time of the report. These children resided with the maternal aunt in a separate household and the mother was an identified caregiver. The allegations were unsubstantiated. On 4/17/06, an SCR report alleged Choking/Twisting/Shaking and Excessive Corporal Punishment against the father regarding the 16-year-old male sibling; these allegations were unsubstantiated. On 11/20/11, an SCR report alleged Emotional Neglect and Inadequate Guardianship against the maternal grandmother regarding the 16-year-old male sibling; these allegations were unsubstantiated.

Known CPS History Outside of NYS

There is no known history outside of New York.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

Preventive Services were previously opened to the mother and 16-year-old sibling on 7/18/05. SCDSS focused on the following service needs: mother's consistent participation in mental health counseling and medication management; 16-year-old sibling's involvement in after school programming that included some clinical support; and case coordination services to assist mother with public assistance benefits and other matters. The mother consistently participated in her own mental care without prompting. The 16-year-old sibling completed the after school programming, graduated, and received aftercare support. The mother was able to resolve matters related to public assistance and other benefits on a continual basis. The Preventive Services case was closed on 2/2/07 upon determination that no further risk factors or service needs were present.

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?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

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