Child Fatality Report

Report Identification Number: AL-22-017

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

Issue Date: Oct 17, 2022

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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 4 year(s)
Jurisdiction: Schenectady
Gender: Female
Date of Death: 05/15/2022
Initial Date OCFS Notified: 05/15/2022

Presenting Information

Schenectady County Department of Social Services (SCDSS) received a report from the SCR, alleging that on 5/15/22, the SC laid down for a nap and the father found the SC lying face down and not breathing at 6:30PM, when he checked on her. The parents brought the SC next door to a relative's home and called 911. The family had begun mouth to mouth resuscitation on the SC. Police and EMS arrived at the relative's home, took over life saving measures and transported the SC to the hospital. Hospital staff were unable to resuscitate the child and she was pronounced deceased. The SC had a cough for a week and a half prior to the fatal incident and the parents did not seek medical attention. The parents had no explanation for the SC's death.

Executive Summary

This report concerns the death of the 4-year-old female subject child that occurred on 5/15/22. At the time of the child's death, she resided at home with her mother, father, and siblings, aged 7 and 10-years-old.

SCDSS conducted the investigation with law enforcement and learned the subject child had a developmental disability, was nonverbal, and had been sick with a cough for about two weeks. The parents purchased over-the-counter cough medicine but did not bring the subject child to the doctor. On 5/15/22, at around 1:00PM, the father found the subject child asleep on the floor in her bedroom behind the door, he picked her up, put her in her bed and let her sleep. Around 6:00PM, the father realized the subject child had not woken from her nap and went to check on her. The father reported he found the subject child facedown, not breathing, and blue in color. The father asked the mother what to do, the mother did not know, and they brought the subject child next door to the paternal grandmother's home where 911 was called. First responders arrived at the residence, took over resuscitation efforts and transported the subject child to the hospital where she was pronounced deceased.

SCDSS assessed the safety of the 7 and 10-year-old surviving siblings. The 7-year-old sibling had a diagnosed developmental disability and required a higher level of supervision. It was determined that, due to the parents' unwillingness to provide adequate supervision of the children, a safety plan would be necessary. The siblings were temporarily cared for by the paternal grandmother. The parents acknowledged playing video games in their bedroom, while the children were home and left unsupervised. SCDSS learned that the children had not been seen medically in several years and the subject child was not up to date with immunizations or well child visits.

An autopsy was performed, and the final autopsy and listed the manner of death as natural causes. The cause of death was due to diffuse anoxic encephalopathy in a background of myocarditis and pneumonia associated with COVID-19 infection. No evidence of trauma was identified.

SCDSS offered the family bereavement services and the family declined. Burial assistance was provided to the family. SCDSS indicated and closed the case. At the close of the investigation the SSs were assessed safe with the parents and the family was residing with the paternal grandmother.

PIP Requirement
SCDSS will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS 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:**
  - **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:
SCDSS made an appropriate determination based on the evidence obtained throughout the investigation.

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:
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

Issue:	Failure to provide notice of report
Summary:	SCDSS did not provide notice of existence letters to the adults listed on the report within the required time frame.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	There is no PIP required as ARO had been monitoring this issue in their master PIP and SCDSS has shown significant improvement with sending notification of existence letters timely.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/15/2022 **Time of Death:** 07:30 PM

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

County where fatality incident occurred: Schenectady
Was 911 or local emergency number called? Yes
Time of Call: 06:43 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

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	4 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)

LDSS Response

SCDSS conducted a timely investigation into the SC's death. They spoke with the source of the report, medical examiner, law enforcement and EMS. They reviewed records from the pediatrician, conducted home visits and searched history.

SCDSS interviewed the parents, and they reported the SC had a developmental disability, was nonverbal, and had been sick for about two weeks with a cough. The parents reported the SC was fussier and more irritable a few days prior to the fatality. The parents had not sought medical attention regarding the cough, and had given the subject child over-the-counter cough medicine and melatonin to help her sleep. The parents had not brought the subject child to the doctor because the parents did not believe in doctors. The 7-year-old SS had a cough prior to the fatal incident and the parents had not sought medical attention for him. The father reported he found the SC asleep on the floor and put her in her room for a nap around 1:00pm. The parents and the SSs played video games for most of the day, while the SC napped. Sometime around 6:00pm the father realized the SC had not woken from her nap and went to check on the SC and found her face down and not breathing. The father carried the SC into the parents' bedroom and asked the mother what to do, the mother did not know, and they brought the child next door to the grandmother's home and the grandmother called 911.

The investigation revealed the parents had not provided the children with appropriate supervision. The mother stated they had a loose parenting style and there was no set time, structure, or routine for any of the children. The parents admitted to substance use daily and had played video games for hours while the children were awake and unsupervised. SCDSS asked about the parents substance use and the parents reported they do not use at the same time and there was always a sober caretaker. There was no indication the parents were under the influence at the time of the fatal incident. While the parents had been in the home and were available to the children if needed, two of the children had special needs, and all the children were left to care for themselves and meet their own needs.

The parents reported the SC had a developmental disability, but she had not been formally diagnosed. The parents reported the SC had exhibited some of the same features and behaviors of the 7-year-old SS, that was diagnosed with a developmental disability at the age of 4-years-old; therefore, the parents assumed the SC had the same developmental disability. SCDSS contacted the pediatrician regarding the SC and SSs. The SC was last seen in 2020, the 7-year-old-sibling was last seen in 2019 and the 10-year-old sibling was last seen in 2018. After the fatal incident SCDSS had the parents take the SSs to be evaluated medically and there were no concerns.

SCDSS spoke with collaterals. The medical examiner and the pediatrician reported there was no way to determine if the parents had sought medical treatment that it would have prevented the SC's death. The medical records from the pediatrician records confirmed that the SC was behind on well child visits and had not been seen since 2019. LE closed their investigation and there were no criminal charges filed.

The family was offered grief counseling and declined the services. SCDSS provided the family with burial assistance for the SC. SCDSS unsubstantiated the allegations of DOA/Fatality against the mother and father, substantiated the allegations of IG, LS and LMC for the SC, and LS regarding the SSs. At the close of the investigation the safety plan was no longer in place, the SSs were assessed safe with the parents and the family was residing with the paternal grandmother. The family decided residing with the grandmother helped to provide more support and better supervision of the SSs.

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 referred to an OCFS approved Child Fatality Review Team?No
Comments: Schenectady County does not have an approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060508 - Deceased Child, Female, 4 Yrs	060510 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
060508 - Deceased Child, Female, 4 Yrs	060510 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated

060508 - Deceased Child, Female, 4 Yrs	060510 - Mother, Female, 28 Year(s)	Lack of Medical Care	Substantiated
060508 - Deceased Child, Female, 4 Yrs	060510 - Mother, Female, 28 Year(s)	Lack of Supervision	Substantiated
060508 - Deceased Child, Female, 4 Yrs	060511 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
060508 - Deceased Child, Female, 4 Yrs	060511 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
060508 - Deceased Child, Female, 4 Yrs	060511 - Father, Male, 26 Year(s)	Lack of Medical Care	Substantiated
060508 - Deceased Child, Female, 4 Yrs	060511 - Father, Male, 26 Year(s)	Lack of Supervision	Substantiated

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 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 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:
SCDSS offered the family services and they declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
SCDSS offered the family services and 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? No
Was the child acutely ill during the two weeks before death? No

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

In 2017, the mother was named as the subject in an unfounded investigation regarding the subject child with the allegation of Parent's Drug Alcohol Misuse.

Known CPS History Outside of NYS

The 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