Child Fatality Report

Report Identification Number: SY-22-030

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

Issue Date: Dec 02, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: St. Lawrence
Gender: Male
Date of Death: 06/19/2022
Initial Date OCFS Notified: 06/21/2022

Presenting Information

On 6/21/2022, St. Lawrence County Department of Social Services (SCDSS) notified OCFS of the death of a 4-month-old child (SC) through an OCFS Agency Reporting Form. The child, his mother (BM), and his father (BF) were involved in an open investigation at the time of his death. SCDSS received a subsequent SCR report on 6/19/2022 which alleged the child was in critical condition and the mother was unable to be reached by hospital staff to make decisions for his medical care. The child died as a result of his medical condition on 6/19/2022.

Executive Summary

This report concerns the death of a 4-month-old child which occurred while in the care of his parents. The child was born with gastroschisis and had corrective surgery after his birth. The child was hospitalized in the NICU from birth until 6/13/2022, at which time he was discharged to the care of his mother and father. There was an open investigation with SCDSS following the birth of the child due to concerns the father had several other children removed from his care in the past. The allegations were investigated, and it was determined the father and mother were able to provide adequate care for the child and he was discharged to their care from the NICU.

On 6/18/2022, the child was in the care of the babysitter until approximately 6:00 PM. The babysitter stated the child was fed through his g-tube and vomited a clear liquid which was normal following a feeding. The babysitter stated the child was picked up by the parents and appeared normal. The parents stated the child continued to vomit clear liquid throughout the night and they contacted the NICU where the child had been previously admitted and were advised to bring him to the hospital. The child was stabilized, and airlifted to another hospital. Upon his arrival to the second hospital the child was diagnosed with acute hypoxemic respiratory failure, ischemic bowel, ischemic hypovolemic shock, hypoglycemia, hyperkalemia, hemorrhagic shock, acute pulmonary hemorrhage, and acute respiratory distress syndrome. The hospital staff were unable to reach the mother by phone to discuss his medical treatment and a second SCR report was made due to the inability to treat the child without the mother's consent. SCDSS was able to reach the mother by phone following the receipt of the SCR report and she contacted the hospital. The hospital informed the mother and SCDSS the child had passed away during the time from when the report was received until contact was made. There was a concern for the initial delay in medical treatment due to the parents not bringing the child to the hospital sooner, and the hospital's inability to treat the child without the mother's consent. The hospital later stated both the delay in treatment and the inability to contact the mother would not have saved the child's life. The autopsy showed signs of dehydration and an undiagnosed bowel issue which was what led to the child's death.

The mother and father were participating in voluntary services at the time of the child's death. Additional services were offered and declined, citing the existing services in place. The investigations open at the time of the child's death were unsubstantiated and closed. The child died from complications of his medical diagnoses and not as a result of abuse or maltreatment.

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?** 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? 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:
There was detailed documentation in the case record of supervisory consult throughout the investigation.

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: 06/19/2022 **Time of Death:** 01:23 AM

Date of fatal incident, if different than date of death: 06/18/2022
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: St. Lawrence
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? N/A
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	No Role	Male	4 Month(s)
Deceased Child's Household	Father	No Role	Male	32 Year(s)
Deceased Child's Household	Mother	No Role	Female	19 Year(s)

LDSS Response

SCDSS received an SCR report on 6/19/2022, which alleged the SC was in critical condition and the BM was unable to be contacted by hospital staff to make decisions, delaying medical treatment. SCDSS was able to reach the SM by phone who then contacted the hospital. SCDSS then followed up with the hospital to ensure the BM had made contact and was informed the SC had passed away. The SC had a medical history of gastroschisis and had corrective surgery upon his birth. The SC was admitted to the NICU from birth until 6/13/2022. The SC passed away on 6/19/2022 and SCDSS informed OCFS of the SC's death through an OCFS Agency Reporting Form.

SCDSS interviewed the BM and BF in their home. The BM and BF stated the SC had been at the babysitter's home on 6/18/2022 and she reported he had been vomiting clear liquid, which was normal after feeding through his g-tube. The BM stated the SC continued to vomit into the night and the parents contacted the NICU at the hospital where the SC was admitted. NICU staff advised the parents to bring the SC to the hospital, which they did at approximately 3:00 AM. The BM and BF stated they were with the SC until he was airlifted to a second hospital, and they were not able to go with him and had no transportation to the hospital. The BM and BF stated they spoke with the hospital at approximately 12:00 AM and did not hear from the hospital again until they were contacted by SCDSS and then called the hospital and were informed the SC had passed away.

SCDSS interviewed the SC's babysitter. The babysitter stated she had been caring for the SC often during the week prior to his death, including overnight on two occasions, due to the parents' work schedules. The babysitter confirmed the SC began to vomit clear liquid on 6/18/2022 while in her care. The babysitter stated this was common for the SC after he was fed through the g-tube and would stop shortly after. The babysitter stated the SC appeared to be fine when he was picked up from her home by the parents at approximately 6:00 PM.

SCDSS was informed by hospital staff the parents brought the SC to the hospital at 3:00 AM on 6/18/2022 due to excessive vomiting. The SC was then airlifted to a second hospital in the late afternoon on 6/18/2022. The second hospital informed SCDSS the SC was diagnosed with acute hypoxemic respiratory failure, ischemic bowel, ischemic hypovolemic shock, hypoglycemia, hyperkalemia, hemorrhagic shock, acute pulmonary hemorrhage, and acute respiratory distress syndrome. The parents and first hospital had informed them the SC had a 12-hour period of vomiting bile and showed signs of dehydration. The hospital confirmed multiple unsuccessful calls were made to the parents to discuss treatment prior to his death. The attending physician stated the parents were aware the SC had been vomiting bile for several hours and did not seek medical treatment, hoping it would subside. The parents then contacted the NICU where the SC had been previously admitted and were advised to bring the SC to the hospital immediately. The attending physician stated there was difficulty getting in contact with the BM by phone, though did not believe the delay in contact would have made a difference in preventing the SC's death. The attending physician also stated the BM and BF should have brought the SC to the hospital sooner but did believe the SC would have died regardless of when medical treatment occurred. The attending physician stated the autopsy showed signs of dehydration and bowel issues.

The BM and BF were offered services in relation to the death of the SC. The parents were engaged in services previously

set up for them in an open voluntary services program and stated they would continue with those services. The open investigation was unsubstantiated and closed.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The fatality was referred to 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?	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Services were offered and only financial assistance with funeral costs was accepted by the family. The family continued to utilize existing services.

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? 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)
06/19/2022	Deceased Child, Male, 4 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 4 Months	Mother, Female, 19 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SCR report alleged the SC was hospitalized and the hospital was unable to contact the BM to make medical decisions for him.

Report Determination: Unfounded | **Date of Determination:** 07/21/2022

Basis for Determination:
SCDSS was informed by hospital staff the delay in medical treatment and inability to contact the BM would not have changed the prognosis for the SC. The SC died during the open investigation and the autopsy showed signs of dehydration and a bowel issue.

OCFS Review Results:
SCDSS conducted an investigation which met regulatory requirements and made a determination of the allegations in congruence with the evidence obtained.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/16/2022	Deceased Child, Male, 1 Months	Father, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
The SCR report alleged the BM gave birth to the SC on 2/9/2022. The report stated the BF had his parental rights terminated for his other children due to his inability to care for the children due to his substance abuse, criminal activity and a lack of supervision. The SC was in the NICU since birth and there were concerns for discharging home in the care of the father. The BM had an unknown role.

Report Determination: Unfounded | **Date of Determination:** 07/21/2022

Basis for Determination:
The SC was born with a birth defect which required surgery and hospitalization following his birth. The BF initially attempted to deny paternity to SCDSS to attempt to avoid further CPS investigation. The BF did cooperate with the investigation and signed releases for his service providers and agreed to random drug screenings. The drug screens were

negative for illicit substances during the investigation. Through familial and collateral contacts, no concerns were identified for the SC being discharged to the care of the BM and BF. The SC was discharged to their care on 6/13/2022 and died on 6/19/2022.

OCFS Review Results:
SCDSS conducted an investigation which met regulatory requirements. No concerns were identified for the BF's substance misuse and he was engaged in treatment. The investigation was ongoing at the time of the SC's death, which was attributed to complications of his birth defect.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/23/2020	Other Child - BF's child, Female, 1 Days	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	Yes
	Other Child - BF's child, Female, 1 Days	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - BF's child, Female, 1 Days	Other Adult - BM to OC, Female, 27 Years	Inadequate Guardianship	Substantiated	
	Other Child - BF's child, Female, 1 Days	Other Adult - BM to OC, Female, 27 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SCR report alleged the BM to the OC gave birth on 5/22/2020. The child was born at home and at the time of the birth, the BF and the BM to the OC were impaired from methamphetamine use.

Report Determination: Indicated **Date of Determination:** 08/06/2020

Basis for Determination:
The child was born at home prematurely and transported to the hospital. While at the hospital, the BF and BM to the OC were incoherent, aggressive towards staff members, and failed to make a plan for the care of the OC. A neglect petition was filed and the child was removed from the care of the BF and BM to the OC and she was placed in foster care. The parental rights of the BF and BM of the OC were terminated in 2021.

OCFS Review Results:
Relevant information was obtained by SCDSS from collateral sources. While attempted home visits and casework contacts are documented in a separate FSS, there was no documentation in the case record or the FSS case record the alleged subjects were interviewed regarding the allegations in the report. The OC was placed in foster care due to the substance misuse concerns present in the household.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
There was no documentation the BF and mother of the OC were interviewed. The only documented casework contact with them in the case record was a court appearance. Although COVID protocols were being followed and home visits and contacts were attempted, there was no documentation the subjects of the report were interviewed virtually or face-to-face regarding the allegations.

Legal Reference:
18 NYCRR 432.1 (o)

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

[redacted]

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

The BF has a significant CPS history dating back to 2013 with substantiated allegations for drug misuse in 2016 and 2017. The father and former partners have all had substance misuse issues for which services were provided. The BF has 6 other children that were removed from his care and for whom his parental rights have been terminated. The BF has no contact with those children.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Foster Care Placement History

The BF had his 6 eldest children removed from his care in 2016, 2017, and 2020, upon their births. Services were provided and neither the BF or the biological mothers to his other 6 children participated in them to completion. The BF's parental rights were terminated to each of his 6 other children in 2018 and 2021.

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