Child Fatality Report

Report Identification Number: AL-21-029

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

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This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Rensselaer
Gender: Female
Date of Death: 11/07/2021
Initial Date OCFS Notified: 11/10/2021

Presenting Information

Rensselaer County Department of Social Services (RCDSS) was present on 11/5/2021 for a suicide attempt of a 17-year-old child (SC) who was involved in an open investigation. The mother (BM) had called to inform RCDSS she was having issues with the child's behavior and needed assistance. Upon their arrival, the mother informed RCDSS the child was upstairs in her room. The RCDSS caseworkers went upstairs to talk with the SC and found her unresponsive in the bathroom with a lanyard wrapped around her neck. A call was made to 911 and first responders transported the child to the hospital where she was placed on life support. The child was removed from life support and pronounced dead on 11/7/2021. The child died during an open an CPS investigation from 10/19/2021 which alleged concerns the BM did not follow through with recommended medical treatment for the SC following an overdose of illicit substances. RCDSS informed OCFS of the child's death through an OCFS Agency Reporting Form.

Executive Summary

This report concerns the death of a 17-year-old child which occurred while in the care of her mother. On 11/5/2021, the mother called her assigned caseworker with RCDSS and informed her she was unable to control the behaviors of the child. The child was acting aggressive towards her, and the mother went outside the home to call RCDSS for assistance.

RCDSS went to the home immediately and the mother brought them inside to speak with the child. The mother informed RCDSS the child was upstairs in her room and the caseworkers went up to speak with her. The child was not found in her room and the mother and caseworkers then checked the bathroom. The mother unlocked the bathroom door, and the child was found unresponsive with a lanyard wrapped around her neck. A call was made to 911 and the child was transported to the hospital by first responders. The child was pronounced brain dead, removed from life support, and died on 11/7/2021.

At the time of the child's death, RCDSS had an open investigation regarding the child's illicit drug misuse, and the mother's failure to follow recommended medical treatment for the child. On 10/15/2021, the child ingested an unknown quantity of illicit drugs and required medical intervention. Medical intervention occurred at the child's pediatrician's office and the family was then sent by ambulance to the hospital. The mother and child confirmed they left the hospital without being seen for follow up because the child wanted to leave. The child had a history of substance misuse and mental health concerns. A referral to substance abuse treatment was given to the mother and she was working to set the services up at the time of the child's death.

RCDSS offered the mother services in relation to the death of the child. The mother accepted burial assistance and declined other services. The allegations against the mother on the open report for Child's Drug/Alcohol Use, Inadequate Guardianship, Lack of Medical Care were substantiated. RCDSS closed the open investigation and ended their involvement with the family after obtaining relevant information regarding the child's death.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**

- **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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 contains detailed documentation of supervisory consult throughout the open investigation and following the death of the SC.

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: 11/07/2021 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 11/05/2021
Time of fatal incident, if different than time of death: 11:00 AM

County where fatality incident occurred: Rensselaer
Was 911 or local emergency number called? Yes
Time of Call: 11:13 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
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
How long before incident was the child last seen by caretaker? 30 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **Waiting for assistance**

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	17 Year(s)
Deceased Child's Household	Mother	No Role	Female	43 Year(s)

LDSS Response

On 11/5/2021, RCDSS received a call from the BM stating the SC was out of control in the home. The BM stated the SC was throwing items, yelling, and being aggressive towards her following an argument with the SC's girlfriend. The BM stated she found a hidden knife in the SC's bedroom which she removed. RCDSS informed the BM they would come to the home immediately and the BM stated she would wait outside for their arrival.

RCDSS arrived at the home approximately 20 minutes later. The BM brought the caseworkers inside and informed them the SC was in her bedroom upstairs. The caseworkers went upstairs to speak with the SC and did not hear any sounds coming from her bedroom. The caseworkers and the BM unlocked the bathroom door and found the SC unresponsive with a lanyard wrapped around her neck. A call was made to 911 and CPR was initiated on the SC. LE and EMS arrived at the home and the SC was transported to the hospital where she was revived and placed on life support. The SC was pronounced brain dead on 11/7/2021, and succumbed to her injuries and died on 11/10/2021.

The BM stated the SC had not expressed any suicidal ideation or had made any threats of suicide prior to the BM and RCDSS finding the SC unresponsive. The BM disclosed the SC had a history of self-harm and she had found and removed a knife from the SC's room.

RCDSS spoke with LE following the fatal incident. LE confirmed the SC had an argument with her girlfriend the morning of her suicide and in the computer messages threatened to commit suicide and to possibly ingest drugs. The SC had a history of drug misuse and RCDSS was investigating allegations in relation to the SC's overdose on opiates on 10/15/2021. LE informed RCDSS there would be no criminal charges in relation to the SC's death.

RCDSS offered the BM services in relation to the death of the SC. The BM accepted assistance with financial assistance for the funeral and declined other services. There were no surviving minor siblings.

The allegations of CD/A, IG, and LMC regarding the SC were substantiated against the BM. The SC ingested an unknown amount of illicit drugs and required medical intervention. The BM brought the SC to the hospital for treatment and left before being seen. The BM brought the SC to the pediatrician's office where she received emergency treatment and was sent back to the hospital by ambulance for further observation. The BM and the SC then left the hospital before being seen for follow up treatment and observation. The SC had a history of marijuana misuse the BM was aware of. Prior to the death of the SC, the BM had not obtained proper substance abuse or mental health treatment the SC needed.

Official Manner and Cause of Death

Official Manner: Suicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Rensselaer County has an OCFS approved child fatality review team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐

Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM accepted assistance with burial expenses. The BM was offered additional services which were 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/19/2021	Deceased Child, Female, 17 Years	Mother, Female, 43 Years	Childs Drug / Alcohol Use	Substantiated	No
	Deceased Child, Female, 17 Years	Mother, Female, 43 Years	Inadequate Guardianship	Substantiated	

	Deceased Child, Female, 17 Years	Mother, Female, 43 Years	Lack of Medical Care	Substantiated

Report Summary:
RCDSS received an SCR report which alleged on 10/15/2021, the 17-year-old SC ingested an unknown amount of illicit substances and emergency intervention was required. There was a medical recommendation for further observation and testing. The BM did not follow through with recommended treatment.

Report Determination: Indicated | **Date of Determination:** 01/05/2022

Basis for Determination:
The BM and SC confirmed the SC had ingested the illicit substance and was taken to the hospital by the BM. They were not seen in a timely manner and sought medical intervention from the SC's pediatrician. The pediatrician sent the SC to the hospital by ambulance. The BM and SC confirmed they left the hospital the second time without being seen for the recommended follow up and observation. The SC had a history of marijuana misuse and mental health concerns that were not being adequately addressed by the BM. The SC attempted suicide on 11/5/2021 and succumbed to the injuries she sustained on 11/7/2021.

OCFS Review Results:
RCDSS conducted an investigation that met regulatory requirements. A referral for services was made for the child and services were in the process of being set up at the time of the SC's death.

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)
05/18/2021	Deceased Child, Female, 16 Years	Mother, Female, 43 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 16 Years	Mother, Female, 43 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Female, 16 Years	Sibling, Female, 25 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 16 Years	Sibling, Female, 25 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Female, 16 Years	Sibling, Female, 19 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 16 Years	Sibling, Female, 19 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:
The SCR report alleged the BM and adult siblings physically assaulted the 16-year-old SC, leaving marks and bruises. The SC ran from the home and the BM failed to make a plan for her care.

Report Determination: Indicated | **Date of Determination:** 07/29/2021

Basis for Determination:
The SC alleged the incident occurred and the BM and adult siblings denied the incident occurred as reported. The BM stated the SC and one of her siblings were fighting and the BM attempted to restrain the SC, not assault her. The SC did sustain some scratches and bruises as a result of the incident. The SC left the home and would not return. The SC stayed with her girlfriend and her family. The BM was advised to contact probation to address the SC's behavioral concerns in the home. The allegations against the BM and adult siblings were substantiated due to their failure to meet a minimum standard of care by engaging in a physical altercation with the SC and failing to plan for her care.

OCFS Review Results:
RCDSS conducted an investigation that met regulatory requirements. RCDSS obtained information from relevant collateral sources and made a determination of the allegations in congruence with the evidence gathered.

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)
02/04/2021	Deceased Child, Female, 16 Years	Mother, Female, 42 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Female, 16 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged the BM was failing to provide adequate care for the 16-year-old SC and was providing the SC's prescribed medication to other family members. The BM was aware of an adult male coming to the home and touching the SC inappropriately and failed to intervene. The report alleged there was little food in the home and the BM does not provide the SC with food.

Report Determination: Unfounded **Date of Determination:** 03/31/2021

Basis for Determination:
RCDSS interviewed the family members and obtained information from relevant collateral sources. The investigation revealed the SC was sexually abused by a minor cousin, not an adult, when she was 11 years old. The BM took appropriate steps to ensure the safety of the SC after learning of the sexual abuse. The SC was displaying ungovernable behaviors in the home and the family was referred to probation and the BM filed a PINS petition with the court. Additional services were set up for the BM and the SC prior to the investigation being closed. The investigation revealed no concerns for a lack of food in the home.

OCFS Review Results:
RCDSS conducted an investigation that met regulatory requirements and made a determination of the allegations in congruence with the evidence gathered.

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

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

There were four cases that were more than 3 years old, two of which were substantiated. Allegations were substantiated due to the BM allowing a minor sibling to smoke marijuana in the home in the presence of the now adult children, and for leaving the children unsupervised for an extended period of time.

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