Child Fatality Report

Report Identification Number: AL-23-011

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

Issue Date: Nov 21, 2023

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 had an open investigation or a CPS monitored services 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: 1 month(s)
Jurisdiction: Warren
Gender: Female
Date of Death: 05/31/2023
Initial Date OCFS Notified: 05/31/2023

Presenting Information

Warren County Department of Social Services (WCDSS) completed an OCFS-7065 Agency Reporting Form on 5/31/23, after learning of the 1-month-old subject child's death. There was an open investigation at the time of the death due to concerns regarding the condition of the home and a delay in medical care for the subject child.

Executive Summary

On 5/31/23, WCDSS was notified by hospital staff that the 1-month-old female subject child passed away on the same date. WCDSS had an open CPS investigation, which began on 4/19/23, due to concerns regarding the condition of the family's residence and a possible delay in medical care for the subject child. Prior to the subject child's hospitalization, she resided with her mother and father. There were no surviving siblings or other children in the household.

WCDSS completed casework and collateral contacts and learned that on 5/1/23, the mother and father brought the subject child to the hospital following an incident in which the subject child appeared to not be breathing properly and changing colors. The mother had initially contacted emergency medical services, who responded but advised the mother to transport the subject child to the hospital due to the subject child's vitals appearing normal and there not being a need for ambulatory services. Upon arrival at the hospital, the subject child was evaluated and transferred to a different hospital for a higher level of care. The subject child was admitted into the Neonatal Intensive Care Unit (NICU) and diagnosed with bacterial meningitis, sepsis, ventriculitis with seizures, infarcts, leukocytosis bandemia, and hydrocephalus. The subject child was noted to have a small brain bleed; however, hospital staff reported no concerns for intentional trauma. The subject child received intensive medical care and remained hospitalized until her death on 5/31/23.

An autopsy was not performed, and the death was not referred to a medical examiner or coroner. The hospital physician declared the cause of death as central apnea due to, or as a consequence of, bacterial meningitis, and the manner of death was natural. WCDSS did contact law enforcement; however, a criminal investigation was not opened as there was no suspicion of abuse or maltreatment regarding the subject child's medical status at that time.

Bereavement services were offered and declined by the parents. WCDSS provided the parents with resource packets if the parents felt services were needed in the future. The allegations from the open CPS investigation were unsubstantiated as it was reported by hospital staff that the cause of the bacterial meningitis could not be linked to negligence on the parent's behalf and that seeking medical care sooner would not have changed the subject child's outcome.

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

Explain:
This was a non-SCR reported fatality and therefore, no determination was required.

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.

Explain:
Casework was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/31/2023 **Time of Death:** 07:28 AM

Date of fatal incident, if different than date of death: 05/01/2023
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Warren
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested 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	No Role	Female	1 Month(s)
Deceased Child's Household	Father	No Role	Male	40 Year(s)
Deceased Child's Household	Mother	No Role	Female	19 Year(s)

LDSS Response

WCDSS began gathering information regarding the fatal incident at the time the SC was hospitalized on 5/1/23.

The BM and BF were interviewed, and the BM reported that on 5/1/23, the BM observed the SC was not breathing properly and her lips were turning white. The BM contacted the BF who was at work to tell him he needed to come home. The BF's boss advised the BM to contact 911. The BM hung up and immediately called 911. EMS and LE responded to the home but reported the SC was observed to be breathing normally and appeared normal in color. EMS stated it did not appear the SC needed to be transported via ambulance and advised the BM to bring the SC to the hospital for further evaluation. The BM did not have transportation, and therefore, waited 20 to 30 minutes for the BF to arrive home. The BM and BF then immediately brought the SC to the hospital where she was evaluated and transferred to another hospital for a higher level of care. The SC remained hospitalized and in critical condition until her death on 5/31/23. The BM denied noticing any other incidents in which the SC stopped breathing prior to when she called 911. The BM reported the SC had not been eating as much as normal, and she contacted the pediatrician to schedule an appointment for 5/3/23 to address this concern. WCDSS confirmed this appointment with the pediatrician. The BM stated she noticed the SC's foot and leg twitched, but that this had been occurring since birth. The BM addressed this with the hospital staff at birth and was told it was normal; however, was informed after the SC was admitted to the NICU that the twitches were seizures. The BF denied observing anything wrong with the SC.

WCDSS contacted the SC's pediatrician and confirmed the SC was seen on 4/21/23, 4/22/23, 4/24/23, and an appointment was scheduled for 5/3/23 which was canceled that morning of due to the SC's admission to the NICU. The pediatrician noted no concerns for the SC's health and only noted concerns regarding finances, housing, and transportation for the parents. The SC was born full-term with no reported complications.

WCDSS was in consistent communication with medical staff regarding the SC's medical care and status. The SC's nurse practitioner did not feel there was a delay in medical care by the parents. The hospital's social worker did report there being a delay in seeking medical treatment; however, stated this delay would not have affected the SC's medical outcome.

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: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: WCDSS does not have 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
WCDSS offered the family bereavement services; however, the parents declined services stating they were not needed at that time.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Grief services were offered to the family and declined. WCDSS provided the family with grief resources in case the family changed their mind.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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)
04/19/2023	Deceased Child, Female, 1	Mother, Female, 19	Inadequate Food / Clothing /	Unsubstantiated	No

Days	Years	Shelter	
Deceased Child, Female, 1 Days	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 1 Days	Mother, Female, 19 Years	Lack of Medical Care	Unsubstantiated
Deceased Child, Female, 1 Days	Father, Male, 40 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Female, 1 Days	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 1 Days	Father, Male, 40 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
The SCR report alleged the BM gave birth to the SC. There were no safe sleep arrangements in place for the SC. The residence was a converted garage with concrete floors. There were wires hanging creating a safety hazard, and 5 dogs in the home who defecated and urinated on the floor. There was no crib, bassinet, or playpen as the items could not fit in the space. The BM, BF, and PGM did not arrange an adequate environment for the SC. Two subsequent reports were received that alleged the BM and BF were aware the SC was not eating properly, was lethargic, and would stop breathing and failed to seek medical attention for 3 to 4 days. The residence did not have heat, running water, or bathrooms.

Report Determination: Unfounded | **Date of Determination:** 06/14/2023

Basis for Determination:
The parents moved one week prior to the SC's birth and WCDSS observed necessities and adequate housing for the SC. The SC was not eating as much so the BM made a pediatric appointment. The BM reported when the SC was not breathing properly and had white lips, she called 911. EMS did not have concerns for the SC. The BM took the SC to the hospital for follow-up. The SC was admitted to the NICU for bacterial meningitis on 5/1/23 where she remained until her death on 5/31/23. The hospital had no concerns for abuse or maltreatment and did not feel seeking medical care sooner would have changed the SC's outcome. The cause of the meningitis could not be linked to negligence by the parents.

OCFS Review Results:
The report was initiated within 24 hours by Saratoga County Department of Social Services (SCDSS) and transferred to WCDSS upon gathering information that the family resided in Warren County. All relevant collaterals were contacted. Documentation was thorough and timely. WCDSS remained in consistent communication with medical staff and the parents to receive updates regarding the medical status of the SC and to offer support to the family. Home visits were made, and the parents were interviewed regarding the allegations of the reports, as well as safety and risk. All regulatory requirements were met.

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

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

The BF had an unfounded case from 8/2015 with allegations of IG and PD/AM against the BF regarding two children unrelated to the fatality. There were concerns of substance misuse, and it was learned the BF had been arrested for involvement in a methamphetamine lab; however, not in the presence or residence of the children.

Known CPS History Outside of NYS

There was no known 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