Child Fatality Report

Report Identification Number: SY-21-038

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

Issue Date: Jan 13, 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		
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: 15 year(s)
Jurisdiction: St. Regis
Gender: Female
Date of Death: 08/07/2021
Initial Date OCFS Notified: 08/08/2021

Presenting Information

An SCR report alleged on 8/7/21, the 15-year-old female subject child went on a two mile run around 10:00 PM. When the child returned from her run, she went to the bathroom. At 10:30 AM, she was found laying on the floor and was deceased. At the time of her death, she was in the care of family friends. The family friends were made alleged subjects as they were the caregivers for the child at the time of her death. The role of the mother was unknown.

Executive Summary

This fatality report concerns the death of the 15-year-old female subject child that occurred on 8/7/21. A report was made to the SCR the following day which alleged the child was found unresponsive on the bathroom floor after the child had gone for a run. At the time of the fatal incident, the child was being cared for by family friends. The family friends and the child were at a dinner party with other adults at the time of the fatal incident. There were no surviving siblings or other children residing with the child.

St. Regis Mohawk Tribe (SRMT) coordinated investigative efforts with law enforcement upon receipt of the SCR report. Law enforcement closed their investigation without criminal charges. An autopsy was performed; however, the results were not yet made available at the time this report was written.

SRMT gathered information from the family friends, the hosts of the dinner party and the mother who stated the child had a history of cardiac surgeries. Despite the child's past surgeries to correct a heart defect, the child was cleared for physical activity and had no restrictions noted by her pediatrician or cardiologist.

The investigation revealed the child was an avid runner and went for a jog during the dinner party. When she returned, she appeared fine and went into the bathroom. When the child did not come out of the bathroom, she was discovered unresponsive and not breathing. EMS was contacted and CPR was performed until first responders arrived and took over resuscitation efforts. The child was transported to the hospital via ambulance where she was pronounced deceased.

SRMT made collateral contacts with first responders including police officers, paramedics and firefighters, the parents and those attending the dinner party. There were no concerns for abuse or maltreatment of the child. Additionally, SRMT contacted the child's pediatrician and cardiologist who did not have information as to why the child passed away and did not have concerns for her health at the time of her passing.

SRMT completed required reports and the investigation reflected that of best casework practice. SRMT appropriately unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the family friends. SRMT determined the family friends provided a minimum degree of care to the child, and their actions or inactions did not play a role in the child's death. Grief services were offered to the adults. It remained unknown if the mother engaged in the services; however, the family friends declined further involvement with SRMT. Additionally, SRMT offered the mother a case with Adult Protective Services as she was in search of suitable housing. The mother was noncompliant with the services and the case was closed.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The decision to close the case was appropriate.

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 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: 08/07/2021 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 10:00 PM

County where fatality incident occurred: Jefferson
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 alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant

☐ Playing ☐ Eating ☐ Unknown
☒ Other: In the bathroom

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	15 Year(s)
Deceased Child's Household	Mother	No Role	Female	56 Year(s)
Other Household 1	Father	No Role	Male	59 Year(s)
Other Household 2	Other Adult - Family Friend	Alleged Perpetrator	Female	43 Year(s)
Other Household 2	Other Adult - Family Friend's husband	Alleged Perpetrator	Male	47 Year(s)

LDSS Response

On 8/7/21, SRMT received the fatality report from the SCR. Within the first 24 hours of the investigation, SRMT contacted law enforcement, documented a CPS history check, notified the district attorney's office of the death and contacted the source of the report.

Hospital staff reported the child arrived at the hospital in cardiac arrest at 11:45 PM and was declared deceased at 11:48 PM. The child was cold to the touch and rigor mortis had set in. The dinner hosts' 6-year-old child attempted to go in the bathroom but was unable as the door was locked and the subject child did not answer him. The 6-year-old child alerted the adults who unlocked the door and discovered the child unresponsive and not breathing.

SRMT conducted a home visit alongside law enforcement who had previously interviewed the family. Through interviews, it was learned that the child had two heart surgeries in the past but was considered healthy and medical professionals did not have medical concerns for the child. The family friends who were caring for the child were interviewed. The child had been staying with them for approximately two weeks prior to the fatal incident. On the day of the child's death, she slept until around noon, which was typical for her, and went for an afternoon run. The child later took a nap and then went shopping with the female family friend. The child went for another run then had dinner with the family friends around 7:45 PM at a dinner party. When the child returned from her run, she was upbeat and proud of herself for her accomplishment regarding distance and speed. After dinner, the adults thought the child was in another room while the adults played a card game. Later, the 6-year-old child needed to use the bathroom, but the door was locked. The adults knocked on the door and the child did not answer. The female family friend and a dinner host opened the door and saw the child on the floor, unresponsive. They began CPR and 911 was called. EMS responded and took over resuscitation efforts to no avail. The dinner hosts corroborated what was reported by the family friends. The 6-year-old child stated the subject child was passed out in the bathroom or was sick and was aware law enforcement was present and the adults prayed. He did not have additional information.

The parents were contacted. The mother said the child had been cleared for all activities after her heart surgeries and recovery. The father had not been in the child's life for several years and did not have information regarding the death or

how the child was cared for.

SRMT contacted first responders who reported the child was purple and cold to the touch when they arrived. The child had visible scars on her chest, and it was obvious she had undergone heart surgeries. Firefighters attempted to utilize an AED with their resuscitation efforts; however, the defibrillator advised them not to administer a shock.

The child's cardiologist was contacted and records from the pediatrician and cardiologist were obtained. The records reflected there were no concerns for the child's health, nor did she have any physical restrictions. The cardiologist was unable to provide an explanation as to why the child may have passed away.

SRMT completed a thorough investigation and met all casework activities timely and with accuracy. Services in response to the death were offered to the family friends but were declined. The mother stated she may attend services in the future and requested assistance in finding suitable housing. The mother was noncompliant with the adult protective services she previously expressed interest in and therefore, the case was closed.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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: St. Regis Mohawk Tribe does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058211 - Deceased Child, Female, 15 Yrs	058214 - Other Adult - Family Friend, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated
058211 - Deceased Child, Female, 15 Yrs	058214 - Other Adult - Family Friend, Female, 43 Year(s)	Inadequate Guardianship	Unsubstantiated
058211 - Deceased Child, Female, 15 Yrs	058215 - Other Adult - Family Friend's husband, Male, 47 Year(s)	DOA / Fatality	Unsubstantiated
058211 - Deceased Child, Female, 15 Yrs	058215 - Other Adult - Family Friend's husband, Male, 47 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

Additional information:
The father was not interviewed face-to-face; however, he did not have a relationship with the child or knowledge of the death.

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.

Have any Orders of Protection been issued? No

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:
The mother was offered Adult Protective Services to assist her in obtaining handicapped accessible housing and treatment for an addiction. The mother was noncompliant with the offered services and the case was closed.

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? N/A
Explain:
There were no surviving siblings. Services were offered to the 6-year-old child; however, he was not listed on the report nor did he reside in the subject household. The services were declined by the family friends on behalf of the 6-year-old child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The adults were offered grief counseling in response to the fatality.

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? Yes
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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

09/12/17- 11/07/17 The mother was unsubstantiated for IG, L/B/W, II and XCP of the child.

03/24/09- 06/12/09- The father was substantiated for IG and PD/AM of the child.

Known CPS History Outside of NYS

There was no known history outside of New York.

Preventive Services History

01/11/11- 12/27/11 An Out-of-Town Inquiry was opened as the BM and SC moved to Onondaga County (OCDSS) and Services would help them transition. The BM was released from prison and reunited with the SC when the SC was nearly freed for adoption. The BM was court-ordered for preventive services, expiring on 03/22/11. OCDSS provided casework counseling, transportation and mental health referrals. The case was closed as the BM did not want further intervention with the county. The case was closed without casework activity between 09/29/11 and 12/27/11.

06/12/09- 10/08/10 The BF was arrested for DWI with the SC in the car on 03/24/09 and an Article 10 Neglect Petition was filed. Preventive mandated services were ordered to prevent placement. An OOP was issued against the BF and he was ordered not to consume drugs or alcohol. The BF appeared at court and was intoxicated. The BF was court-ordered to a mental health evaluation and intensive alcohol treatment. The BF was arrested for violating his probation and the SC was placed in the custody of her grandmother on 07/15/09 via an Article 10 placement. Custody was transferred to OCDSS on 08/28/09 as the grandmother could not care for the SC. The mother obtained custody and the SC was discharged from Foster Care on 09/12/10.

Foster Care Placement History

The child was removed from the care of the father after he was arrested and incarcerated for DWI while the child was in the car. At the time of the incident, the mother was incarcerated. The child was placed with the grandmother on 07/15/09 via an Article 10 placement. When the grandmother could no longer care for the child, the child went into Foster Care in August of 2009. On 09/12/10, the mother obtained custody of the child and she was discharged from Foster Care.

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