Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-19-037

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: Warren
Gender: Male
Date of Death: 12/01/2019
Initial Date OCFS Notified: 12/04/2019

Presenting Information

On 12/4/19, the death of the 17-year-old subject child was reported to OCFS by the Warren County Department of Social Services (WCDSS) through the required Agency Reporting Form 7065. The child passed away in the hospital on 12/1/19 at 9:59 AM.

Executive Summary

On 12/3/19, the Warren County Department of Social Services (WCDSS) was notified by the father that the 17-year-old male subject child passed away on 12/1/19 at 9:59 AM. WCDSS had an open CPS investigation at the time, which was received on 8/9/19, that alleged the child was diagnosed with a developmental disability and learning disability and the father and his partner were locking the child in his bedroom at night and leaving marijuana accessible to the child. Evidence gathered did not support the allegations. During the investigation it was learned the child was admitted to an inpatient psychiatric center on 10/6/19, after an incident in which he physically assaulted the father. The father obtained an order of protection against the child on 11/21/19 and the child was scheduled to be transferred to a residential treatment facility upon discharge. There were no other children residing in the home and the father and his partner had no other minor children.

WCDSS investigated the circumstances surrounding the child's death and learned on 11/29/19, the child was found unresponsive in the bathroom of the psychiatric center by a staff member and they called 911. The child was brought to the hospital via ambulance and then transferred to another hospital for a higher level of care. The child had a shunt due to a congenital condition and he was found to have excess fluid on his brain. The child was placed on life support until 12/1/19, when medical intervention was withdrawn and he passed away. The outcome of the law enforcement investigation was not documented, and it was not documented if an autopsy was completed.

The father and his partner were provided with funeral assistance and information on bereavement services. The child's mother was deceased.

WCDSS determined the child's death was not the result of abuse or maltreatment by a caretaker. The incident remained under investigation with the Justice Center at the time WCDSS closed their case. Although it was determined the child retained fluid on his brain and became unresponsive, at the time this report was written, the cause of death remained unknown.

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:
The death of the subject child was not reported to the SCR as there was no suspicion the death was the result of abuse or maltreatment. WCDSS thoroughly investigated the circumstances surrounding the child's death and appropriately closed their case.

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 best casework practice.

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: 12/01/2019 **Time of Death:** 09:59 AM

Date of fatal incident, if different than date of death: 11/29/2019
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Oneida
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: Bathroom

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

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	17 Year(s)
Deceased Child's Household	Father	No Role	Male	42 Year(s)
Deceased Child's Household	Father's Partner	No Role	Female	44 Year(s)

LDSS Response

WCDSS conducted a thorough investigation of the incident. Within 24 hours of learning of the child's death, WCDSS submitted the Agency Reporting Form 7065 to the Regional Office. They gathered information about the child's death by contacting law enforcement, school staff, staff at the psychiatric center, the child's therapist and Parson's worker. They received and reviewed records from both hospitals that treated the child and the child's pediatrician. WCDSS interviewed the paternal grandmother, the father and the father's partner and conducted home visits at the father's home.

Through interviews, it was learned that the child had been complaining of headaches for several weeks prior to his death and staff provided him with over-the-counter medication to alleviate the symptoms. The child was also vomiting and staff thought he had a virus. On 11/29/19, the child was relaxing in one of the common rooms and he went into the bathroom. Staff went in to check on him when he had not come out and they found him unresponsive on the floor. Staff immediately called 911. The child arrived at the hospital at 2:45 PM and was transferred to the second hospital at 5:40 PM. Upon arrival to the hospital it was discovered the child's shunt was not working properly and he had excess fluid on his brain. Staff reported the child had been in two recent altercations where he had been hit by other patients and it was unknown if these altercations affected the child's shunt.

There were no concerns noted for the father's care of the child and collateral contacts stated that he was meeting the child's medical and mental health needs. The father was actively participating in the child's care and he made an appropriate plan for the child.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Warren County 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?	☒	☐	☐	☐

Additional information:
It was not documented if the medical examiner was involved or if there was an autopsy performed.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were referred for bereavement counseling and they were provided with funeral assistance.

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? N/A
Was the child acutely ill during the two weeks before death? Yes

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)
11/21/2019	Deceased Child, Male, 17 Years	Father, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report alleged the subject child was ready to be discharged from a psychiatric facility and the father had an order of protection against the child and he had no plan for the child's discharge.

Report Determination: Unfounded | **Date of Determination:** 02/16/2020

Basis for Determination:
The father was actively involved in the child's treatment and he had a plan for the child to be transferred to a residential treatment facility upon discharge from the psychiatric facility. On 11/29/19, the child became unresponsive and was admitted to the hospital and was put on life support. He passed away on 12/1/19, and it was determined the child's death was not the result of abuse or maltreatment by the father.

OCFS Review Results:
WCDSS interviewed the father and his partner and assessed the father's home to be safe. Upon receipt of the report, Oneida County DSS interviewed the child at the psychiatric facility. All necessary collaterals, including the child's treatment providers, were spoken to. The Safety Assessments and RAP were completed accurately and timely and the required persons were notified of the report. WCDSS thoroughly investigated the circumstances surrounding the child's death when he passed away during the investigation.

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)
08/09/2019	Deceased Child, Male, 17 Years	Father, Male, 42 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Deceased Child, Male, 17 Years	Father, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 17 Years	Father's Partner, Male, 44 Years	Excessive Corporal Punishment	Unsubstantiated	
	Deceased Child, Male, 17 Years	Father's Partner, Male, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 17 Years	Father, Male, 42 Years	Poisoning / Noxious Substances	Unsubstantiated	

Report Summary:
An SCR report alleged the subject child was diagnosed with a developmental disability and a learning disability and the father and his partner locked him in his bedroom at night. The adults were making and selling marijuana candies that were left accessible to the child. The adults were making the child do wall sits and run for miles as punishment. The child was suicidal as a result of the father and his partner's behavior.

Report Determination: Unfounded **Date of Determination:** 02/16/2020

Basis for Determination:
The father admitted to using marijuana that was prescribed for medical purposes. The child reported he was made to exercise for his health, but it was not excessive. The father reported the child was not able to be left alone due to his diagnosis. There was no lock on the child's bedroom door, but there was a motion sensor on his door and a camera in his bedroom for his safety. The father said the child was suicidal in the past and he had been hospitalized. The child was hospitalized on 10/3/19, after he physically assaulted the father. The child was admitted to an inpatient psychiatric hospital and he was later found unresponsive and he passed away.

OCFS Review Results:
WCDSS conducted home visits at the father's home and interviewed the father, his partner and the child. Oneida County DSS assessed the child to be safe at the psychiatric center. Safety Assessments and the RAP were completed accurately and timely and the required persons were notified of the report. WCDSS contacted the child's service providers and other necessary collaterals and determined the father was meeting the child's needs. The circumstances surrounding the child's death were thoroughly investigated.

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

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

There was an extensive history of unfounded SCR reports from 1999-2015 against the father regarding the subject child and another child.

An SCR report dated 5/18/12 was indicated against the mother for Inadequate Guardianship regarding the subject child.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Preventive Services History

A Preventive Services case was opened from 5/3/12-2/14/12 to provide services to the father, mother and subject child.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 11/21/2019	**To:** Unknown
Explain: A temporary order of protection was issued in Family Court on 11/21/19 against the subject child ordering him to stay away from the father.	

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