Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-22-010

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

Issue Date: Aug 29, 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	

Case Information

Report Type: Child Deceased
Age: 9 day(s)
Jurisdiction: Saratoga
Gender: Female
Date of Death: 03/23/2022
Initial Date OCFS Notified: 03/23/2022

Presenting Information

Saratoga County Department of Social Services (SCDSS) received a report from the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) which alleged the 9-day-old subject child (SC) died while in the care of her mother (SM) and maternal grandmother (MGM). The mother and grandmother put the child in her car seat and drove to a medical appointment for the mother. Upon arrival at the doctor's office at approximately 11:00 AM, the mother learned the child had vomited and become unresponsive. The mother went into the office for assistance and the medical staff brought the child inside where they began CPR. Medical staff called 911 and the child was transported to the hospital by ambulance. In the two days prior, the child's extremities were blueish in color, and she had blood in her diaper. The mother was aware and failed to seek medical attention. The child was pronounced dead at 2:30 PM after several hours of life saving interventions were attempted at the hospital.

Executive Summary

This report concerns the death of a 9-day-old child which occurred while in the care of her mother and maternal grandmother. The child was placed by the mother into her car seat. The mother and maternal grandmother drove to a doctor's appointment and upon their arrival, the mother found the child unresponsive in the car seat. The mother and grandmother brought the child into the office for medical attention and a call was made to 911 by medical staff. The child was transported by ambulance to the hospital where she was pronounced deceased by hospital staff after several hours of resuscitation attempts. There were no surviving siblings or other minor children living in the home.

Law enforcement was contacted and confirmed they conducted interviews with the mother and maternal grandmother without SCDSS present. Law enforcement would not share details of their investigation, citing potential criminal charges being pursued. Law enforcement stated their investigation was pending the results of the autopsy, which were not available at the time this report was written.

SCDSS met with the maternal grandmother prior to the family's attorney ceasing contact with SCDSS due to the pending criminal investigation. The maternal grandmother stated the child had blood in her diaper for two days prior to her death, which they attributed to a diaper rash. The maternal grandmother confirmed the events of the fatal incident and shared no further details after speaking with her attorney.

SCDSS made multiple attempts to interview the family and offer services in relation to the death of the child. Their attempts were denied by the family's attorney and their investigation remained open at the time this report was written.

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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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:
The investigation remained open at the time this report was written.

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: 03/23/2022 **Time of Death:** 02:30 PM (Approximate)

Time of fatal incident, if different than time of death: 11:00 AM

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 alcohol or drugs? No
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
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **N/A**

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	9 Day(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Other Household 1	Grandparent	No Role	Male	45 Year(s)

LDSS Response

SCDSS received the SCR report, contacted the source for further information, and coordinated their response with LE. SCDSS was informed by LE that the SM and MGM brought the SC with them to a medical appointment for the SM.

SCDSS interviewed the hospital staff that worked on the SC upon her arrival. SCDSS was informed the SM stated she had seen blood in the SC's diaper for the previous 2 days and the SC seemed cold and bluish in color the morning of the fatal incident. The SM stated to hospital staff that the SC ate at 4:30 AM and did not eat again prior to her 11:21 AM arrival at the hospital. The hospital staff attempted several hours of resuscitation efforts, and the SC had a blood sugar level of 11, and difficulty clotting when bleeding. The SC may have had a blood clotting disorder or bled excessively due to the resuscitation efforts. Hospital staff stated the SC had multiple bruises on her body the day she died: bruises on her groin, neck, abdomen, leg, and armpit area. The SC did not have any bruising noted on 3/21/22 during an appointment with her pediatrician. Multiple collateral sources provided varying information for the cause of the bruising. Some sources attributed the armpit bruising to how the SC was handled (being pick up under her arms, picked up by the back of her outfit). Another source said the armpit area bruising could have been caused by CPR. The record said according to LE, the SM said, "She had been rough with the baby, she got impatient." SCDSS was not able to interview the SM for clarification of this statement due to the advice of her attorney. At the time this report was written, there was no documented definitive cause of the bruising.

SCDSS performed a home visit to interview the SM and MGM once LE stated they could speak with the family. The MGM was interviewed in the home. The MGM stated the SC's pediatrician had wanted the SC to gain more weight, and that she was not eating well. The MGM stated she and the SM had seen blood in the SC's diaper and attributed it to being from diaper rash. On the day of the fatal incident, the MGM stated the SC generally did not eat well and they had a medical appointment at 11:00 AM for the SM, and an appointment for the SC at 1:45 PM. The SM placed the SC in the car seat, and they drove to the SM's appointment. Upon arrival, the SM stated to her that the SC was bluish in color, she had spit up, and was unresponsive. The SM and MGM brought the SC into the medical office where 911 was called by staff and the SC was transported to the hospital. SCDSS spoke with the MGM about services available and their willingness to provide them. The MGM then received a phone call and advised SCDSS the family would no longer speak to them regarding the investigation on the advice of their attorney.

SCDSS interviewed the SC's pediatrician. The pediatrician stated the SC had lost weight since birth, though it was not a concerning amount. The family was advised to increase feedings and were bringing the SC in for regular weight checks. The pediatrician stated there were no calls made to their office regarding blood in the SC's diaper or other concerns for her on the day of her death.

SCDSS spoke with LE. LE informed SCDSS they would not share details from their interviews with the SM or MGM

pending their criminal investigation. The coroner stated there was no preliminary cause of death available and the results of the autopsy were pending and being completed by the ME.

SCDSS made multiple attempts to interview the family and offer services, including reaching out to the family's attorney to arrange interviews. The requests were denied citing the pending criminal investigation. SCDSS informed the family's attorney the investigation would remain open until interviews could be completed. The BF was unknown to SCDSS and his identity was unable to be confirmed due to the lack of contact with the family. The investigation remained open at the time this report was written.

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 investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: Saratoga County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060905 - Deceased Child, Female, 9 Days	060906 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Pending
060905 - Deceased Child, Female, 9 Days	060906 - Mother, Female, 19 Year(s)	DOA / Fatality	Pending
060905 - Deceased Child, Female, 9 Days	060906 - Mother, Female, 19 Year(s)	Internal Injuries	Pending
060905 - Deceased Child, Female, 9 Days	060906 - Mother, Female, 19 Year(s)	Lacerations / Bruises / Welts	Pending
060905 - Deceased Child, Female, 9 Days	060906 - Mother, Female, 19 Year(s)	Lack of Medical Care	Pending
060905 - Deceased Child, Female, 9 Days	060906 - Mother, Female, 19 Year(s)	Malnutrition / Failure to Thrive	Pending
060905 - Deceased Child, Female, 9 Days	060907 - Grandparent, Female, 45 Year(s)	DOA / Fatality	Pending
060905 - Deceased Child, Female, 9 Days	060907 - Grandparent, Female, 45 Year(s)	Inadequate Guardianship	Pending
060905 - Deceased Child, Female, 9 Days	060907 - Grandparent, Female, 45 Year(s)	Lacerations / Bruises / Welts	Pending

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:
SCDSS attempted interviews with both the family and collateral contacts. The family would not speak to SCDSS pending the criminal investigation and LE would not share details of their investigation with SCDSS.

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:
SCDSS offered the family services in relation to the death of the child, though the family ceased contact with SCDSS before services could be accepted or declined. The investigation remained open at the time this report was written and it was documented in the case record services would be offered to the family before the investigation was closed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered to the family, though the family ceased contact with SCDSS on advice of their attorney.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

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 fetal alcohol effects or syndrome

☒ With neither of the issues listed noted in case record

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

There was no CPS investigative history more than three years prior to the fatality.

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