Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-22-006

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

Issue Date: Jul 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: 14 day(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 02/19/2022
Initial Date OCFS Notified: 02/22/2022

Presenting Information

On 2/19/22, Albany County Department of Children, Youth and Families (ACDCYF) learned of the death of the 2-week-old male subject child that occurred on the same day. There was an open CPS investigation at the time of the death. ACDCYF notified the Albany Regional Office via the 7065 Agency Reporting Form within the required timeframe.

Executive Summary

On 2/19/22, ACDCYF was notified of the death of the 2-week-old male child by the hospital and paternal grandmother. At the time of the fatality, the family had an open CPS investigation, which began on 2/7/22. The CPS investigation alleged concerns for the mother and child's positive toxicology at the time of the child's birth and the mother's homelessness. The father had another child, age 3-years-old, who resided with his mother. The sibling was not informed of the subject child's birth or death. The sibling had limited and supervised contact with the father and was assessed via a video-call to be safe in the care of his mother.

The subject child was diagnosed with a positive toxicology for amphetamines and cocaine and was diagnosed with medical conditions which affected his brain. The mother reported drug use during her pregnancy and received no prenatal care. The child was admitted to the NICU and had a poor prognosis for survival. ACDCYF maintained contact with the hospital staff to discuss the child's condition and monitor the parents' contact with the child while admitted. There were several plans of care discussed by hospital staff, including discharge to the family with end of life care or children's hospice care at a facility. There were concerns for the parents being under the influence and the father injecting drugs into the mother's IV prior to her discharge from the hospital. In the event the child was discharged from the hospital, ACDCYF intended to remove the child and place him in LDSS custody. The child's condition continued to decline, and the parents were at the child's bedside under supervision of hospital personnel. The child remained in the NICU and died on 2/19/22.

ACDCYF documented conversations with medical personnel, who indicated an autopsy would be completed and that the autopsy could determine if the mother's drug use was the cause of the child's congenital condition that resulted in his death. ACDCYF documented attempts to obtain information regarding the autopsy report. On 4/13/22, ACDCYF was informed that an autopsy was not completed and the child's body was released to the funeral home. It was stated that an autopsy was not needed due to there being no suspicion regarding the death that would have warranted an autopsy examination. Due to there not being an autopsy, it was unknown if the child's death was the result of abuse or maltreatment by the mother.

The hospital provided the family with funeral assistance and ACDCYF documented efforts following the death to offer the parents services; however, they were undomiciled and unable to be contacted. The CPS investigation open at the time of the death was indicated and closed on 4/21/22.

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? 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:
ACDCYF gathered information surrounding the circumstances of the death, made efforts to offer appropriate services and closed the CPS investigation that was open at the time of the fatality.

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: 02/19/2022 **Time of Death:** 05:00 PM (Approximate)

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Albany
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: Hospitalized

Did child have supervision at time of incident leading to death? Yes

At time of incident was supervisor impaired? Unknown if they were impaired.

At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **In the same room**

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	14 Day(s)
Deceased Child's Household	Father	No Role	Male	30 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)

LDSS Response

ACDCYF had an open CPS investigation with the family at the time of the child fatality. The case was opened on 2/7/22, after the subject child was born with a positive toxicology for amphetamines and cocaine. The child's health was poor at the time of his birth and he remained hospitalized from birth until the time of his death. Upon notice of the death on 2/19/22, ACDCYF completed the required 7065 Agency Reporting Form, contacted the hospital, assessed the sibling for safety and offered services regarding the fatality.

ACDCYF gathered information from hospital staff and completed interviews with the child's doctors. The subject child was born via C-Section and was diagnosed with medical conditions that affected his brain. He was unable to suck, swallow, and he had no brain activity. The child's brain was completely filled with fluid. The child was not eating on his own and his vitals were sporadic. The child experienced mild withdrawal symptoms and displayed seizure-like activity. The doctor reported if the child lived, he would only develop to 3 to 6 months and his development would be devastating. The child would be unable to walk or talk and he would need a G-tube in addition to other medical interventions. Medical procedures, such as the removal of the fluid in the child's brain or placement of a shunt would not change the outcome. ACDCFY asked if any of the child's medical concerns were caused by the mother's substance misuse. The child's doctor stated the lack of brain activity may have been caused by the mother's drug use while pregnant, but one of his medical conditions was not typically related to substance misuse. The doctors reported that the results of the autopsy would conclusively determine if the mother's drug use was the cause of the child's congenital conditions. It was unknown if the mother's drug use, or any other maltreatment from the mother, caused the child's death. The hospital would not know what caused the child's death, or whether the mother was responsible for the death of the child until the autopsy was conducted.

The mother reported she did not have a permanent residence and had been living on the streets prior to the child being born. The mother discovered she was pregnant at 6-months. The mother stated she was malnourished during her pregnancy and had used illicit substances, including heroin three weeks prior to the child's birth. The mother refused any medical interventions to prolong the child's life if they would not improve the child's condition and signed a Do Not Resuscitate (DNR) order and a Do Not Intubate (DNI) order. The father of the child was not interviewed as he was not present while

CPS was at the hospital and had no contact information or address.

On 2/9/22, the hospital determined it was unknown how long it would take for the child to die and began to develop a plan to discharge the child home for end of life care. ACDCYF documented a legal consultation and it was determined if the child was discharged from the hospital then a removal would be conducted. The paternal grandmother visited the child while he was hospitalized; however, was unable to be a placement resource for the child. On 2/10/22, the child's condition worsened and he was no longer eligible for discharge.

During the open CPS investigation, the father was discovered by nursing staff injecting drugs into the mother's IV and was escorted out of the hospital. The mother and father were observed to be impaired by hospital personnel. The father was permitted back into the hospital when the child began to deteriorate. ACDCYF requested that the child not leave the NICU without supervision. Hospital personnel determined it was permissible for the parents to be at the child's bedside so they could spend time with him prior to his impending death. The child was moved into a room across from the nursing station for better supervision and medical staff were aware of the concerns for the parents.

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 referred to an OCFS approved Child Fatality Review Team? Yes

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?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☐	☒	☐
At 7 days?	☐	☐	☒	☐
At 30 days?	☐	☐	☒	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Explain:
As there was no SCR report surrounding the fatality, ACDCYF inquired of relevant collaterals and family members and was informed an autopsy would determine if whether there was reasonable cause to suspect abuse or maltreatment with respect to the SC's death. Although safety assessments in these instances are not required, ACDCYF did assess and document the safety of the surviving sibling via a video-call.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☒	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☐	☐	☒	☐
Was there an adequate assessment of the family's need for services?	☐	☐	☐	☒
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☐	☐	☒	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine

Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☐	☒	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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:
The family was provided funeral assistance through the hospital. ACDCYF offered the grandmother bereavement counseling and she declined. ACDCYF attempted to provide services to the parents; however, they were unable to contact them due to their homelessness. ACDCYF mailed information on grief counseling for the parents to the grandmother's address.

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:
The 3-year-old sibling was unaware of the subject child's birth and death and was not offered services regarding the fatality.

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? 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
- ☐ 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 neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
02/07/2022	Deceased Child, Male, 2 Days	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Deceased Child, Male, 2 Days	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	

Deceased Child, Male, 2 Days	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Substantiated

Report Summary:
An SCR report was received and alleged that the mother gave birth to the subject child on 2/5/22. At the time of birth, the mother and subject child tested positive for amphetamine and cocaine. The child's health was deteriorating. The father had an unknown role.

Report Determination: Indicated | **Date of Determination:** 04/21/2022

Basis for Determination:
ACDCYF summarized the casework activity completed throughout their investigation. Although the investigation conclusion narrative did not affirmatively state how the evidence gathered supported their determination, ACDCYF gathered a substantial amount of information from collateral sources and casework contacts that supported indicating the report.

OCFS Review Results:
ACDCYF contacted the source, interviewed the mother and paternal grandmother, made efforts to interview the father and maintained contact with the hospital throughout the duration of the CPS investigation. There were several supervisory consultations documented. Notification of existence letters were mailed to the parents. A safety plan was created that required supervised contact with the child; however, this was not reflected in the 7-day safety assessment. The child died during the investigation and ACDCYF gathered information regarding the death from the family and collateral sources.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
On 2/8/22, ACDCYF requested the child not be unsupervised with the parents. This safety plan was not reflected in the 7-day safety assessment tool.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
ACDCYF will document and approve all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

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

In 2018, the father had an unfounded investigation which alleged LBW, IG and CHTS regarding an unrelated child.

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