Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-029

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

Issue Date: Dec 16, 2020

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: 17 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 07/01/2020
Initial Date OCFS Notified: 06/30/2020

Presenting Information

On 7/1/20, the death of the 17-year-old teenager was reported to OCFS by Onondaga County Department of Social Services (OCDSS) through the required Agency Reporting Form 7065. The teenager died on 7/1/20, as the result of an asthma attack.

Executive Summary

On 7/1/20, OCDSS notified OCFS of the subject child's passing on the same date through form 7065. OCDSS had an open Family Assessment Response (FAR) case that was received on 6/19/20, alleging the mother tested positive for marijuana at the time the sibling was born, on 6/17/20.

The subject child was home with his mother, mother's partner, and four siblings, ages 14, 8, 1, and 1-month-old. The subject child went into his mother's room on the evening of 7/1/20 and was struggling to breathe. The subject child collapsed in his mother's room. The mother and her partner carried the subject child downstairs and began cardiopulmonary resuscitation and called 911. First responders arrived and took over efforts then transported the child to the hospital where he was pronounced dead.

It was learned the subject child had been diagnosed with asthma as an infant. The child was not seeing a specialist at the time of his death but was taking his medications as prescribed and checking in regularly with his primary care physician. The record reflected the mother was appropriate in bringing the child to the hospital when his condition was exacerbated.

Due to the conditions surrounding the death, an autopsy was not performed. There were no toxicology reports completed. Law Enforcement did not find any criminality during their investigation into the death.

OCDSS assessed the safety of the siblings. The home was assessed prior to the subject child's death, and there were no concerns. OCDSS provided the mother resources for substance abuse treatment. The mother was adamant that she used the marijuana due to pregnancy symptoms and was no longer using marijuana and did not need additional services related to substance abuse; the infant sibling was not documented to have been affected by the mother's marijuana use. All siblings and the subject child were up to date on vaccinations and their primary care physician did not disclose any concerns. The mother and siblings engaged in grief counseling through a community resource.

OCDSS assisted the family in rectifying the concerns that led to the opening of the FAR case and the case was closed with no additional service needs identified.

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.

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 decision to close the FAR case open at the time of death was appropriate. The death was not an SCR reported 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: 07/01/2020 **Time of Death:** Unknown

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

County where fatality incident occurred: Onondaga
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? Unknown
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 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	Mother	No Role	Female	32 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Month(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Other Adult - Father of the siblings	No Role	Male	36 Year(s)

LDSS Response

On 7/1/20, OCDSS received additional information from the SCR regarding the 17-year-old subject child's passing. OCDSS provided the family with information on bereavement counseling and assessed four surviving siblings, who resided in the home. There were concerns regarding the 1-month-old sibling, which were being explored in a FAR investigation that was open at the time of the death.

OCDSS contacted multiple medical providers about the child's death. Records reflected the child had been diagnosed with asthma since infancy. The child was receiving appropriate medical intervention.

Based on the information gathered, OCDSS determined the child's death was the result of natural causes and not due to abuse or maltreatment by a caretaker. The mother and siblings utilized their community supports and were engaged in bereavement counseling at the time of the FAR case closure.

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 reviewed by 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?	☒	☐	☐	☐

Additional information:
Though this was not an SCR reported fatality, OCDSS coordinated with LE and contacted all relevant collateral sources.

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: The death of the subject child was not reported to the SCR.				

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	☒	☐	☐	☐

Explain:
As there was no SCR report surrounding the fatality, OCDSS inquired of relevant collateral sources and family members as to whether there was reasonable cause to suspect abuse or maltreatment with respect to the subject child's death. OCDSS found there to be no such reason. OCDSS provided the family with referrals to bereavement and mental health counseling. The family was receptive to the referrals and engaged in services at the time of case closure.

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?	☐	☒	☐	☐

Explain as necessary:
There was no removal of any of the surviving siblings.

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:
OCDSS provided the family with referrals for services. The family was receptive and began counseling immediately.

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? Yes
Explain:
OCDSS provided the family with referrals for bereavement and mental health counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS provided the mother with referrals for bereavement and mental health counseling. At the time of the case closure, the mother was engaged in mental health services.

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? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/19/2020	Sibling, Male, 2 Days	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	Yes

Report Summary:
OCDSS received a report from the SCR alleging the mother gave birth to a male sibling on 6/17/20. The mother tested positive for marijuana at the time of delivery.

OCFS Review Results:
The record did not reflect that the family-led assessment guide was initiated and discussed with the family. Documentation did not clearly demonstrate that the worker provided information to the family about CPS response options, including the key difference between the two. Documentation did not clearly state the family's willingness to participate in FAR as opposed to a regular investigation track. OCDSS appropriately determined the death that occurred during the FAR case was not the result of abuse or neglect.

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

Issue:
FAR-Overall Completeness/Adequacy of Family Assessment Response

Summary:
Documentation within the FAR case did not include caseworker efforts to explore and elicit information pertaining to each area of the Family-Led Assessment Guide (FLAG). The record did not reflect the FLAG was completed in close consultation with the family prior to completion of the FAR. Documentation did not clearly state the family's willingness to participate in FAR.

Legal Reference:
18 NYCRR 432.13 (a)(1-4)

Action:
OCDSS will comply with OCFS regulations pertaining to required activities in a FAR case.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/22/2017	Deceased Child, Male, 14 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 5 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 12 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 5 Years	Mother, Female, 29 Years	Educational Neglect	Unsubstantiated	

Report Summary:
OCDSS received a report from the SCR which alleged the then 5-year-old sibling had 32 absences and 11 days tardy for the 2017-2018 school year. The mother was aware of the absences and failed to intervene. As a result of the sibling's absences, she was failing.

Report Determination: Unfounded **Date of Determination:** 05/03/2018

Basis for Determination:
OCDSS determined there was no credible evidence to support the allegations. While the sibling did miss 30 days of school during the 2017-2018 school year, OCDSS did not find evidence to support a negative impact on the sibling.

OCFS Review Results:
Although the 7-day safety assessment tool was not completed in the regulatory time frame, other documentation shows that safety was assessed. The family moved out of jurisdiction during the investigation and OCDSS did not follow through to determine whether the conditions warranting child welfare intervention were ameliorated.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:

During the investigation the family moved out of jurisdiction while there were ongoing concerns being investigated. The case record does not reflect OCDSS took necessary steps to contact the jurisdiction where the family moved to coordinate services or communicate whether concerns had been ameliorated.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

OCDSS will make diligent efforts to contact collaterals. OCDSS will adequately monitor so as to respond to potential safety concerns in a timely and effective manner.

[redacted]

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

The mother had a history dating back to 2003 regarding the subject child. The mother gave birth to the subject child at the age of 15. Between 2003 and 2008, there were numerous indicated reports regarding the mother's failure to meet the needs of the subject child and siblings, once born. Historically, the mother left the children with caretakers who could not provide a minimal degree of care. Additionally, the mother failed to meet the subject child's medical needs related to his asthma.

Known CPS History Outside of NYS

There is no known history outside of New York.

Preventive Services History

A Family Services Stage was opened from 5/30/08 to 10/6/08 due to the mother losing her housing subsidy and failing to use suitable caregivers for the subject child and siblings when needed. The mother was residing with other adults who were engaged in illegal activities and there were several drug busts at her home in the investigation leading up to the Preventive Services Case. Preventive Services ended at the request of the mother, on 10/6/08.

A Family Services Stage was opened from 11/18/11-8/16/12 at the request of the mother. The mother requested support in getting the then 8-year-old subject child into mental health services. The subject child was struggling with his behaviors in school and the mother asked for assistance. The mother also sought guidance in referrals for her own mental health condition. The case closed as the mother stopped engaging in services.

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