Child Fatality Report

Report Identification Number: AL-22-004

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

Issue Date: Jul 21, 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: 16 year(s)
Jurisdiction: Saratoga
Gender: Female
Date of Death: 01/31/2022
Initial Date OCFS Notified: 01/31/2022

Presenting Information

An SCR report was received which alleged that on the morning of 1/31/22, at approximately 7:30AM, the mother and father found the 16-year-old subject child unresponsive in her bed with vomit coming out of her mouth. The last time the parents saw the child was on 1/30/22 around 8:30PM, and the child appeared to be her normal self. The subject child had no preexisting medical conditions and showed no physical signs of injury or trauma. The parents had no explanation for the child's death. There were further concerns the home was unsafe and cluttered with garbage and other items.

Executive Summary

This fatality report concerns the death of a 16-year-old female subject child that occurred on 1/31/22. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother and father. Saratoga County Department of Social Services (SCDSS) received the report and investigated the child's death. An autopsy was performed; however, the completed report remained pending at the time of this writing.

At the time of the child's death, she resided with her mother and two siblings, ages 14 and 17 years old. The children's father had shared custody and saw the children regularly. It was discovered that the subject child had a history of mental health concerns and had been in and out of treatment since she was 12 years old. This history included self-harming behaviors and two suicide attempts, the last being in 2020, and the child had been taking prescribed medication since then. The investigation revealed that on the evening of 1/31/22, the subject child was given her medication by her mother and went to her room to sleep around 7:00PM. The mother and the siblings were also home at that time, and all denied observing any unusual behavior from the subject child. Neither the mother nor the siblings saw the subject child again after she went to bed. The following morning, on 1/31/22, the mother awoke around 7:20AM, and went to wake the subject child so she could get ready for the day. The mother knocked on the door before opening it and observed the subject child lying on her bed on top of the comforter. The mother noted the bedroom felt cold, and the space heater was off, which was unusual. The mother then began calling the child's name as she approached the bed, and the child did not respond. The mother found the child unresponsive with froth around her mouth, and reported she felt cold to the touch; she informed law enforcement and SCDSS that it was clear the child could not be revived. The mother called the father, and then emergency services. First responders arrived at the home, and the child was pronounced deceased at the scene.

SCDSS spoke with family members and collateral sources, including law enforcement, medical professionals, mental health providers, and school staff. Law enforcement found an empty bottle of an over-the-counter antihistamine in the subject child's bedroom, which was believed to be the cause of death. Law enforcement noted the death was not suspicious and appeared to be a suicide. All household members denied observing anything that would have indicated the subject child was suicidal in the days leading up to her death; however, the child did inform her mother on 1/28/22 that she had thoughts of self-harming. The mother intervened appropriately by speaking with the child about the severity of her thoughts and promptly scheduling her an intake appointment with a mental health provider. There was no evidence found to suggest the mother or father's actions or inaction resulted in the child's death, or that the child displayed any outward signs she was planning to take her life. Therefore, the allegations were unsubstantiated, and the case was unfounded and closed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

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:
SCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving siblings.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the 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: 01/31/2022 **Time of Death:** Unknown

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

County where fatality incident occurred: Saratoga
Was 911 or local emergency number called? Yes
Time of Call: 07:30 AM
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
How long before incident was the child last seen by caretaker? 12 Hours
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	16 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Deceased Child's Household	Sibling	No Role	Male	14 Year(s)

LDSS Response

On 1/31/22, SCDSS met with SF and the SSs. SF reported that for the past several years, SC had been struggling with her mental health. SF explained SC had depression and anxiety, mainly regarding school. SF reported he was unaware of any specific reasons as to why school made SC anxious and denied having knowledge SC was bullied. SF reported SC was not seeing a mental health counselor at the time of her death; however, she had an intake appointment scheduled. SF stated SC had 2 previous suicide attempts and was admitted to the hospital once. He explained there was nothing that happened recently that would indicate SC was suicidal. SF said SC had been at SM's since 1/26/22, and SM informed him she did not observe anything unusual or alarming prior to the morning she found SC deceased. He denied any safety concerns for the CHN when with SM. SCDSS then interviewed the 17yo SS. He explained he last saw SC around dinner time on 1/30/22, and that she did not act like anything was wrong. He stated he knew she was having trouble getting to school on time, but that was all. The 17yo reported SM told him what happened the following morning. He denied witnessing anything and had no additional information. The 14yo SS was then interviewed. He also reported he last saw SC around dinner time on 1/30/22 and had not noticed anything unusual regarding her behavior. He explained SM told him what happened the following morning when he awoke, and he did not see anything occur. Neither SS disclosed any safety

concerns while in the care of SM or SF, and the home was observed to be appropriate.

On 2/1/22, SCDSS met with SM at her home. SM's brother was also present. SM reported that on 1/30/22, nothing out of the ordinary occurred. She stated SC woke up that morning and watched TV, as she normally did. SM said she chatted with SC on and off all day, cooked dinner around 4:00PM, and around 7:00PM, SC asked for her medication because she was tired and wanted to go to bed. SM reported she gave SC her pills and did not see her again that night. SM explained she went to bed at 10:00PM and woke up around 7:20AM the next morning. SM said she went into SC's room to wake her and noticed the bedroom was cold and the heater was off. SM reported she called SC's name, and when she got closer, she saw SC had froth around her mouth and was cold to the touch. SM noted it was clear SC was deceased. She reported she called SF, then went downstairs and told her brother. She stated she then called 911. SM and her brother denied hearing anything during the night and stated SC was compliant with her medications. They also denied SC had been showing any signs she was suicidal. SM explained SC began having mental health concerns when she was 12yo and she had been cutting herself. SM stated she talked with SC about it, and she seemed okay until she turned 14 and the cutting began again. SM said she got SC into counseling, and she started medication. SM said SC was doing well, but then there were 2 suicide attempts involving over-the-counter medications. SM explained SC was hospitalized, prescribed medications, and began seeing a therapist. SM explained from September to December 2021, SC was no longer seeing a counselor but was doing great; however, after the holidays, SC started not wanting to go to school. SM said SC denied anyone at school was bothering her. SM reported that on 12/28/21, SC said she was having thoughts about self-harming, and SM asked her "how bad." SM said SC told her she was just having thoughts but agreed to begin counseling again. SM explained the earliest appointment she could get was 2/15/22. SC told SM that was fine and if she started feeling worse, she would let SM know. SM reported she and SF kept medications locked up due to the previous suicide attempts. SM reported she had no concerns surrounding SF's care of the CHN and the home was observed to be appropriate and met minimal standards. LE informed SCDSS that they found an empty bottle of an over-the-counter antihistamine in SC's bedroom but would not know if this was the cause of death until the autopsy report was completed. SCDSS asked SM where SC would have gotten the medication from, and SM explained SC had her own debit card and got an allowance, and probably purchased the pills online. SM reported she did not monitor SC's debit card transactions.

Through further interviews with SM, SF, and the SSs, it was noted SC exhibited certain behaviors when she was decompensating. These behaviors included isolation, staying in her bedroom, and sleeping during the day. All household members were interviewed and denied SC was displaying any of these behaviors in the days leading up to her death. Medical records indicated SM and SF sought treatment for SC when it was needed and followed all recommendations. SC was last seen by her pediatrician on 12/29/21, and he noted no concerns surrounding SC's mood or affect. There were no criminal charges filed against either parent regarding the fatality. Family members were engaged in grief counseling within their community and the investigation was unfounded and closed.

Official Manner and Cause of Death

Official Manner: Suicide
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
Comments: This fatality investigation was conducted by the Saratoga County MDT.

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
060169 - Deceased Child, Female, 16 Yrs	060819 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
060169 - Deceased Child, Female, 16 Yrs	060819 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
060169 - Deceased Child, Female, 16 Yrs	060820 - Father, Male, 41 Year(s)	DOA / Fatality	Unsubstantiated
060169 - Deceased Child, Female, 16 Yrs	060820 - Father, Male, 41 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:

SCDSS interviewed the family and appropriate collateral sources. Progress notes and other documentation were completed and entered timely.

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?	☐	☐	☒	☐

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: SCDSS offered the family appropriate services in response to the subject child's death.				

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: The surviving siblings did not need to be removed as a result of this fatality report.				

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 provided the family with bereavement counseling referrals and information on assistance with funeral costs. The parents and siblings were engaged in grief counseling by the close of the investigation.

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:
SCDSS provided the family with grief and bereavement counseling resources for the surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS provided the family with grief and bereavement counseling resources.

History Prior to the Fatality

Child Fatality Report

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

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