Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-18-002

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

Issue Date: Jun 13, 2018

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 14 year(s)
Jurisdiction: Ulster
Gender: Female
Date of Death: 01/04/2018
Initial Date OCFS Notified: 01/09/2018

Presenting Information

On 1/5/18, the death of the 14 yo SC was reported to OCFS by Ulster County Department of Social Services (UCDSS) though the required Agency Reporting Form 7065 because UCDSS had an open Preventive Services case with SC and MGM at the time. On 1/4/18 around 2:00 PM, SC was found unresponsive in bed and later pronounced deceased by the hospital physician at 3:20 PM.

Executive Summary

On 1/4/18, UCDSS was informed SC passed away at the ER after being found unresponsive in MGM's bed. UCDSS had an open Preventive Services case at the time involving SC and MGM. The case was opened on 2/3/17 due to concerns for SC's MH and behavioral issues at home and school. UCDSS contracted with Coordinated Children's Services (CCS) to provide intensive services to SC and MGM. MGM had been caring for SC since 12/9/11 as a kinship foster parent. SC was removed from BM's care and an Article 10 Neglect Petition was filed due to ongoing DV between BM and her partner at that time, violation of an OP barring the partner from SM, the partner was using drugs and deplorable home conditions. BM and BF also had a history of DV with an OP being violated that barred BF from contact with BM and SC. MGM was awarded kinship guardianship of SC on 4/16/13 as BM and BF had not completed their court ordered services.

On 1/4/18 around 2:00 PM, MGM returned home and found SC to be unresponsive in MGM's bed. MU called 911 and performed CPR until EMS arrived and transported SC to the hospital via ambulance. Resuscitative efforts were unsuccessful and SC was pronounced deceased by the hospital physician at 3:20 PM.

An autopsy was performed and the manner of death was determined to be accidental and the cause of death was acute hydrocodone intoxication. There was no documentation in the case progress notes of LE investigating the incident.

UCDSS learned SC had several MH diagnoses, was taking prescribed MH medication and had 2 prior hospitalizations for suicidal ideation, with the most recent being 8/31/17. SC had pre-existing medical conditions and was also suffering from congestion, blurred vision and upset stomach at the time of her death. After SC's death, MGM discovered a half empty bottle of cough medicine containing codeine in the locked medicine box. MGM was unaware SC knew the code for the locked box and felt SC took the cough medicine to feel better.

BM and BF participated in planning for SC's services and education and they both visited SC frequently. They supported MGM retaining guardianship of SC as she was better able to manage SC's extensive MH, medical and behavioral needs. The 2 yo SS resided with BM. UCDSS assessed BM was meeting SS's needs and he was safe in her care. UCDSS provided BM with a locked box to store medication out of reach of SS. MGM's home was assessed to be safe for SS to visit and medication was observed to be secured in a locked box. UCDSS and CCS spoke to BF, BM, MGP and MU and offered their condolences and support. UCDSS provided information on bereavement services and MGM engaged in MH counseling with her provider.

UCDSS determined SC's death was not caused by abuse or maltreatment by a caretaker. As no service needs were identified for the family, UCDSS closed the Preventive Services case on 3/26/18.

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 SC was not reported to the SCR.

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 decision to close the Preventive Services case was appropriate as there were no service needs identified for the family.

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: 01/04/2018 **Time of Death:** 03:20 PM

Time of fatal incident, if different than time of death: 02:00 PM

County where fatality incident occurred: Ulster
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	Aunt/Uncle	No Role	Male	31 Year(s)
Deceased Child's Household	Deceased Child	No Role	Female	14 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	62 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	68 Year(s)
Other Household 1	Mother	No Role	Female	34 Year(s)
Other Household 1	Sibling	No Role	Male	2 Year(s)
Other Household 2	Father	No Role	Male	33 Year(s)

LDSS Response

On 1/4/18, MGM contacted CCS and notified them SC was found unresponsive and brought to the ER by ambulance. CCS went to the home and spoke to MGM and MU. It was learned MGM was shopping and MU was home with SC. SC took a nap in MGM's bed since she was congested and not feeling well. When MGM returned home around 2:00 PM, SC would not wake up and was making a gurgling sound. MU called 911 and followed the dispatcher's instructions for CPR until EMS arrived. CCS transported MGM to the ER and waited with the MGP, MU, BF and BM for about an hour when they were informed SC passed away. At that time, it was assumed SC had passed away from natural causes. CCS and UCDSS attended the funeral services and offered their support and condolences to the family.

UCDSS spoke to the ME and learned SC passed away from an overdose of hydrocodone. The ME's office investigated whether the overdose was a result of suicide or accidental means. MGM and CCS reported SC had recently been in a better mental state, was getting along better with MGM and BF, had an improved outlook and denied suicidal ideation, resulting in SC's death being ruled accidental. It was learned SC had very high blood sugar at the time of her death and had a metabolic disorder that was not previously diagnosed, despite MGM reporting to SC's doctor that she had been experiencing blurred vision and upset stomach.

MGM and BM were spoken to at the CCS office. MGM stated after SC's death she discovered a half empty bottle of cough medicine with codeine in the locked medicine box and the bottle should have been full. She felt SC took the cough medicine to feel better. MGM kept the box locked except when she was administering medication to SC and said SC must have seen her entering the code.

MGM's home was assessed for safety as SS visited the home often. There were no safety concerns and all medication was observed to be locked and out of reach of SS. BM declined a home visit, although accepted a locked box from UCDSS to secure all medication out of reach of SS. No concerns were expressed for the care of SS.

Through a review of the open Preventive Services case it was learned SC was taking prescribed MH medication, was regularly attending MH counseling and was engaged in services with multiple agencies. SC's behavior had improved at home and at school because of the multitude of services and support provided to the family by UCDSS.

UCDSS spoke to multiple family members, CCS staff, the ME and ER staff to gather the facts and circumstances about the incident. It was determined SC's death was the result of an accidental overdose of hydrocodone and was not due to abuse or maltreatment by a caretaker, therefore the incident did not require a report to the State Central Register. MGM engaged in MH counseling with her provider and the family denied any additional service needs. The Preventive Services case closed on 3/26/18.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
UCDSS made diligent efforts to conduct a home visit at BM's home and see SS, although BM declined. UCDSS did not contact first responders regarding the incident.

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 safety 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 SC was not reported to the SCR, therefore 24-hour, 7-day and 30-day safety assessments were not required. SS's safety was assessed through contact with MGM and BM. BM declined a visit to her home or allow UCDSS to see SS, although accepted a locked box to utilize for medication. No concerns were expressed for SS during the open Preventive Services case.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MGM engaged in MH counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	Yes
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?	Yes

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)
09/12/2017	Deceased Child, Female, 14 Years	Mother, Female, 33 Years	Inadequate Guardianship	Far-Closed	No
	Deceased Child, Female, 14 Years	Mother, Female, 33 Years	Lack of Medical Care	Far-Closed	
	Deceased Child, Female, 14 Years	Grandparent, Female, 62 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 14 Years	Grandparent, Female, 62 Years	Lack of Medical Care	Far-Closed	
	Deceased Child, Female, 14 Years	Grandparent, Male, 67 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 14 Years	Grandparent, Male, 67 Years	Lack of Medical Care	Far-Closed	

Report Summary:
An SCR report alleged on 8/30/17, SC attempted suicide by putting a bag over her head and climbed into the trunk of MGF's car. SC had a cell phone and called BM. SC decided not to kill herself. The MGP were made aware of the incident, but failed to seek services or professional help in a timely manner. There were concerns SM and MGP did not take the incident seriously.

OCFS Review Results:
The case was appropriately tracked FAR. UCDSS engaged the family members and spoke to SC's service providers. SC was assessed to be safe in MGM's care. UCDSS provided casework counseling and stressed the importance of following a safety plan made for SC and to contact service providers in the event of such incidents. The 7-day safety assessment and FLAG were completed accurately and on time. The FAR case closed as SC's service needs were being met through the open Preventive Services case.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/23/2017	Deceased Child, Female, 13 Years	Grandparent, Male, 67 Years	Choking / Twisting / Shaking	Unfounded	No
	Deceased Child, Female, 13 Years	Grandparent, Male, 67 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Female, 13 Years	Aunt/Uncle, Male, 30 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report alleged on 2/22/17, SC, MGF and MU all went out together. While driving back home SC realized she misplaced an item. MU began arguing with SC and asked for her cellphone. SC went to hide the phone when it fell to the floor. MU grabbed SC's arm while he was driving. MGF, who was in the back seat, grabbed SC's other arm. MU parked the car and got out and MGF put SC in a headlock and choked her. MGF punched SC in the ribs and MU punched her in the chest. SC did not sustain any visible injuries, but was sore.

Determination: Unfounded | **Date of Determination:** 04/28/2017

Basis for Determination:
UCDSS appropriately unsubstantiated the allegations of IG and C/T/S against MGF and IG against MU regarding SC. SC had a long history of behavioral and MH issues. SC's account of the incident was inconsistent, SC had no marks or bruises and she expressed no fear of her caretakers. SC admitted to punching MGF in the face several times and MGF and MU admitted to restraining SC when she became out of control. SC was engaged in MH counseling and a PINS diversion program. The case was closed and the open Preventive Services case remained open.

OCFS Review Results:
All household members were interviewed and the home was assessed to be safe. Necessary collaterals were contacted and had no concerns for SC's safety in the care of the MGP. Notice of Existence letters were provided to the required persons. Service needs were adequately assessed and offered through the Preventive Services case.

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

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

6/16/2008: Unsubstantiated the allegations of IG and LMC against BM and BF regarding SC.
12/17/2010: Unsubstantiated the allegations of IG against BM and her partner regarding SC.
4/12/2011: Unsubstantiated the allegations of IG against BM, as well as IG and L/B/W against BM's partner regarding SC.
5/19/2011: Substantiated the allegation of IG and Unsubstantiated the allegation of LMC against BM and her partner regarding SC.
12/7/2011: Substantiated the allegations of CD/A and IG against BM's partner and IG against BM regarding SC.
10/19/2012: Unsubstantiated the allegations of IG and SA against BM's partner regarding SC.
11/2/2012: Unsubstantiated the allegation of IG against MGM regarding SC.
8/1/2013: Unsubstantiated the allegations of IG and SA against BM's partner regarding SC.
12/10/2014: FAR case with allegations of IF/C/S, IG, and LMC against MGM regarding SC.

Known CPS History Outside of NYS

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

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 02/03/2017

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
Ulster County Coordinated Children's Services (CCS) provided intensive Preventive Services.

Preventive Services History

A CPS services case was opened 12/9/11 due to ongoing domestic violence in the home involving BM and her partner at the time. The SC was present during verbal and physical altercations over a period of two years, and stay away orders of protection against BM's partner and SC's BF were not adhered to, placing SC at risk. The home was in deplorable condition and drug paraphernalia was found. SC was removed from BM's care via 1022 on 12/9/11, and an Article 10 Neglect Petition was filed in Family Court on 12/15/11. SC was placed in a relative foster home with her MGM. BM and BF had not completed their court orders, and on 4/16/13, MGM was granted kinship guardianship of SC. The CPS services case was closed on 4/24/13.

On 02/03/17, an intensive Preventive Services case opened with CCS and involved MGM and SC. The family was referred to CCS by SC's MH provider. SC had ongoing MH and behavioral issues at home and at school and required intensive services. MGM and SC engaged in services with CCS, Bridges to Health, PINS Diversion, Families Now and Families Together. SC died on 1/4/18 and a plan amendment was completed on 1/17/18. UCDSS closed the case on 3/26/2018, after the facts and circumstances surrounding SC's death were gathered.

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