Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-21-003

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

Issue Date: Jun 30, 2021

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: Warren
Gender: Male
Date of Death: 01/12/2021
Initial Date OCFS Notified: 01/12/2021

Presenting Information

Warren County Department of Social Services received a report from the SCR alleging that on 1/11/21 at 11PM, the mother and father went to bed with the 14-day-old subject child between them. As a result, the child subsequently died. The child was otherwise healthy and the parents had no explanation for his death. This was not an isolated incident as the parents frequently co-slept with the subject child.

Executive Summary

On 1/12/21, the Warren County Department of Social Services (WCDSS) received an SCR report regarding the 14-day-old infant's death that occurred on the same date. At the time of the infant's death, he resided with his mother, father, and 2-year-old sibling.

WCDSS conducted a joint investigation with law enforcement and learned that on 1/11/21, the mother fed the subject child and then placed him to sleep in bed with her. The mother stayed up and watched television until she fell asleep. The father had been out at a bar on 1/11/21 but returned home around 10PM. He watched television in bed for an unknown length of time before falling asleep. The mother woke first to find the subject child unresponsive. The mother woke the father and the father drove the subject child to the hospital as he believed that would be faster than waiting for first responders to arrive. The subject child presented to the hospital unconscious, unresponsive, flaccid with no spontaneous respiration. Resuscitative efforts were unsuccessful. The subject child was pronounced dead at the hospital at 3:23AM on 1/12/21.

WCDSS and law enforcement were concerned with the parents' drug use as they found paraphernalia in the home and the parents both screened positive for cocaine during an initial urine toxicology screening. A plan was made for the surviving sibling to stay with the paternal grandparents and have supervised contact with the parents until WCDSS deemed it safe for the sibling to return to the parents' care. During the investigation, it was determined the maternal grandmother would be a suitable safety plan for the sibling. The paternal grandfather and maternal grandmother worked with WCDSS to implement a safety plan where both grandparents would share in the caretaking responsibilities for the sibling.

WCDSS completed all investigative requirements timely. At the time of this writing, the autopsy results were pending, and the law enforcement investigation remained open until the release of the final report. The preliminary autopsy report was received, which showed that there was no congenital anomaly or acute disease process found to account for the infant's death, though there was a large amount of blood in the nasal cavity and throat. The medical examiner anticipated the death was the result of suffocation from a possible roll-over and explained that a significant amount of blood was common in suffocation cases.

The investigation remained open at the time of this writing. A Preventive Services case was opened from 2/18/21 to 5/12/21 as a result of the death and subsequent safety planning surrounding the care of the sibling. An Article 10 Neglect Petition was filed in family court on 3/30/21 as a result of the parents' substance abuse and failure to cooperate with WCDSS. Warren County Family Court signed an order of custody and parenting time upon stipulation/consent on 4/26/21. The order granted primary physical custody of the sibling to the maternal grandmother and the parents were given supervised parenting time.

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

Explain:
The investigation remained open at the time of this writing.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The investigation had not been determined at the time of this writing. A preventive services case was opened to provide the grandparents with additional support as they obtained Article 6 custody of the sibling. Services were also provided to the parents in order to assist them in completing conditions outlined in family court in order to be reunified with the sibling.

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: 01/12/2021 **Time of Death:** 03:23 AM

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

County where fatality incident occurred: Warren
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? 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
How long before incident was the child last seen by caretaker? 5 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ Other:

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	Male	14 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

WCDSS began their investigation into the incident upon receipt of the SCR report on 1/12/21. They searched SCR history and spoke to the source of the report, the medical examiner's office, law enforcement, hospital staff, the parents, and the grandparents. They conducted several home visits and they assessed the safety of the sibling throughout the investigation.

Through interviews with the parents it was learned that the infant was born full-term and he was healthy. The parents shared that both children were up to date with well-child visits and immunizations, which was corroborated by receipt of medical records. The parents were aware of safe sleep guidelines and there was a bassinet in the home for the infant. The parents did not utilize the bassinet, reporting the subject child became fussy and cried while in it. As a result, the parents regularly co-slept with the subject child.

The father reported that on 1/11/21, he went to the bar down the street to have a drink with a friend in celebration of the birth of the subject child. The father reported he had one drink and returned home around 10PM. He, the mother, and the subject child all went to bed together in the parents' bed and watched television before falling asleep. The mother woke up in the middle of the night to find the subject child unresponsive. The mother began screaming and woke the father. The father determined it would be fastest to drive the subject child to the hospital themselves rather than await first responders.

The sibling stayed with the maternal grandmother while the parents brought the subject child to the hospital. The maternal grandmother resided in the downstairs apartment and was a frequent caretaker for the sibling.

The maternal grandmother reported that she woke to use the restroom and the mother came into the apartment holding the subject child in her arms. The father was present behind her and they reported they needed to go the hospital immediately. The parents sent the sibling into the apartment and then quickly left with the subject child. She did not share any additional details about the incident. She reported she did not have concerns for the care they provided to the subject child or sibling.

Law enforcement and WCDSS conducted urine toxicology screens on the parents the day of the fatality. The drug screens revealed the parents were positive for cocaine. Both parents admitted to using cocaine two days prior. WCDSS determined a safety plan was necessary for the sibling due to the parents' drug use. The maternal grandmother was willing to be a safety plan for the sibling and signed a safety contract related to not allowing the parents unsupervised around the sibling.

Further contact with substance abuse providers during the investigation revealed the parents continued to abuse both illicit drugs and prescription medications. Treatment providers reported the parents were not cooperative with recommendations and were subsequently discharged from treatment due to noncompliance. The parents became uncooperative with WCDSS and an Article 10 Neglect Petition was filed. The investigation remained open at the time of this writing.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: WCDSS adhered to previously approved protocols for joint investigations by coordinating with law enforcement and notifying the DA's office of the death.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Warren 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
057400 - Deceased Child, Male, 14 Days	057401 - Mother, Female, 30 Year(s)	DOA / Fatality	Pending
057400 - Deceased Child, Male, 14 Days	057401 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Pending
057400 - Deceased Child, Male, 14 Days	057402 - Father, Male, 34 Year(s)	DOA / Fatality	Pending
057400 - Deceased Child, Male, 14 Days	057402 - Father, Male, 34 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
WCDSS contacted all relevant collateral sources. The sibling was not cognitively or developmentally at an age to be interviewed.

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:
Sufficient information was gathered during the investigation to assess risk of the sibling. The sibling was not formally placed in foster care. A safety plan was made for the sibling to be placed with an alternate caregiver. Preventive and community-based services were being provided at the time of this writing.

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?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐

Explain as necessary:
Concerns for the parents' substance abuse arose during investigation of the death. Subsequently, the sibling was placed with the grandparents due to concerns he would not be safe in the parents' care until they engaged in substance abuse treatment. An informal safety plan was made and then a petition was filed in family court. The grandparents obtained Article 6 custody of the sibling, with the parents having supervised visitation.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/30/2021	There was not a fact finding	There was not a disposition
Respondent:	057401 Mother Female 30 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against the mother and father with respect to the sibling. The Article 10 Petition was withdrawn in favor of Article 6 custody to the grandparents. Parents were ordered	

	to be supervised with the sibling at all times. The parents were ordered to engage in substance abuse treatment and, in the event they wanted unsupervised time with the sibling, they would have to petition the court and show engagement in services.

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
WCDSS offered services to the family related to mental health counseling, bereavement services, substance abuse treatment, and assistance with funeral arrangements. An early intervention referral was made regarding the surviving sibling.

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:
Preventive services were provided to the sibling. The child was not engaged in grief or mental health counseling due to his age.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered services related to bereavement, mental health counseling, and substance abuse treatment.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

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

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 history outside of New York State.

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