Child Fatality Report

Report Identification Number: AL-22-028

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

Issue Date: Mar 27, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Otsego
Gender: Female
Date of Death: 10/04/2022
Initial Date OCFS Notified: 10/04/2022

Presenting Information

The SCR report alleged that on 10/4/22, the father put the subject child to sleep on a bed. When the father checked on the subject child, he found that she was not breathing. The father called 911 around 12:19PM. The father was instructed to place the subject child on the floor and begin cardiopulmonary resuscitation. When first responders arrived, they found the subject child on the floor of the bedroom and continued cardiopulmonary resuscitation. The subject child was transported to the hospital, where she was pronounced deceased at 2:00PM. The subject child was an otherwise healthy child, and the father and grandmother, who also resided in the home, provided no explanation for the subject child's death. The subject child had bruising on both sides of her abdomen and on the left side of her neck, near the jawline. The explanation for the bruising did not match the injuries. The subject child was in the care of the father, mother, and grandmother at the time she sustained the bruises.

Executive Summary

This fatality report concerns the death of the 2-month-old female subject child that occurred on 10/4/22. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, and Lacerations/Bruises/Welts against the mother, father, and paternal great-grandmother. At the time of her death, the subject child resided with the mother, father, and paternal great-grandmother, in the great-grandmother’s home. There were no surviving siblings or other children in the household.

Otsego County Department of Social Services (OCDSS) completed collateral and casework contacts and learned that on 10/4/22, the father fed the subject child and put her down for a nap between 10:00-10:45AM. The father put the subject child to sleep on the parents' full-sized bed on her stomach surrounded by pillows and blankets. The father was in the same room and heard the subject child making noise around 12:00PM. The father checked on the subject child, as he heard her cooing, and observed bubbles coming from her mouth. The father told the great-grandmother to call 911, and dispatch instructed the father on how to perform cardiopulmonary resuscitation. When the father picked the subject child up, formula came out of the subject child’s nose. The father attempted cardiopulmonary resuscitation efforts until emergency services arrived and took over. The subject child was transported to the hospital and pronounced deceased at 2:00PM.

An autopsy was performed, and OCDSS received the final cause and manner of death. The cause was listed as asphyxiation due to or as a consequence of etiology undetermined, and the manner was undetermined. The pathology report noted diagnoses of pulmonary congestion/edema, superficial contusions to the right and left lower abdomen, abrasions to the buttocks, abrasions to the left lower chin, lower neck erosion, and the left lung had a positive bacterial culture for pneumonia and Group B Strep. The subject child’s toxicology was negative. The criminal investigation remained open at the time the CPS case closed, and there were no pending criminal charges related to the subject child’s death.

Bereavement services were offered to the family, and OCDSS made a referral to a mental health counselor on behalf of the father. The mother had a previously established counselor and planned to reengage in counseling. The allegations of DOA/Fatality and Inadequate Guardianship against the mother and father were substantiated. OCDSS found there was a fair preponderance of evidence to support that the mother and father failed to exercise a minimum degree of care by placing the subject child in an unsafe sleeping environment. All other allegations were unsubstantiated, and the investigation was closed on 1/31/22.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
OCDSS appropriately determined the allegations of the report based on evidence obtained throughout the investigation.

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:
Casework was commensurate with casework 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: 10/04/2022 **Time of Death:** 02:00 PM

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

County where fatality incident occurred: Otsego
Was 911 or local emergency number called? Yes
Time of Call: 12:19 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No

Child's activity at time of incident:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] 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	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	67 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDSS coordinated their investigation with LE, spoke with collateral sources, reviewed CPS history, and completed a home visit.

OCDSS observed interviews conducted by LE and interviewed the household members and learned that on 10/4/22, the SM left for work around 6:30-7:00AM while the SC was asleep in the parents' full-sized bed. The SF awoke when the SM left for work but went back to sleep with the SC until she awoke around 7:30AM. The SF fed and changed the SC and put the SC down for a nap between 10:00-10:45AM. The SF put the SC to sleep on her stomach with her head to the right. The SF did laundry and watched YouTube in the bedroom where the SC slept. The SF heard the SC “cooing” and described her making “raspberry” sounds. The SF checked on the SC, noticed bubbles coming from the SC’s mouth, and told the PGGM to call 911. The SF was instructed on how to perform CPR. The SF reported that when he picked the SC up to begin CPR, “so much” formula came out. The SF stated he “shut down” and attempted to squeeze the SC’s stomach to get the rest of the formula out. The SF stated he tried to follow dispatch’s instructions the best he could, and EMS arrived in approximately five minutes. EMS took over CPR and continued life-saving measures. EMS advised the SF to call the SM to notify her of what was happening, and the SF did. The SC was transported to the hospital, where she was later pronounced deceased. The SM was at work at the time of the incident and therefore did not have further information regarding the circumstance preceding the SC’s death but did corroborate that the SF told her the same version of events. The PGGM was interviewed and stated the SF screamed the SC was not breathing. The PGGM checked the SC for a pulse but did not feel a pulse and called 911.

At the time OCDSS conducted their home visit, the bedding had been removed from the bed for evidence. EMS observed a sheet, kid-sized blanket, comforter, and pillows on the bed. There were no safe sleep provisions anywhere in the home for the SC. The SM and SF confirmed they had a bassinet; however, it was at the MGM’s home. Medical records confirmed that safe sleep guidelines were reviewed with the SM and SF at the hospital and by the pediatrician. The SM and SF reported regularly co-sleeping with the SC since moving into the PGGM’s residence and that the SC slept on her stomach.

The SM and SF were interviewed regarding the bruises and abrasions noted on the SC. The SM and SF stated the abrasions to the buttocks were a result of an ongoing diaper rash. The SM reported she inconsistently used diaper cream

for a period but used the cream more consistently before the death. The SM and SF reported the erosion to the neck was caused by chaffing from the SC's pajamas. The SF stated that he did not observe bruising to the SC's abdomen that morning when he changed the SC and that the bruises were from the SF squeezing the SC's stomach to get the formula out. The SM and SF stated the bruising to the face/chin was due to the SC falling off the bed. The SM and SF gave conflicting timeframes but stated the SC fell two days to a week prior to the fatal incident and sustained the bruises but was otherwise acting normal. The coroner did not feel the explanations were plausible, but the autopsy and medical evaluations were unable to determine the cause of the injuries.

The SC was last seen by her pediatrician on 9/12/22, and there were no concerns. The SC was up to date on vaccinations, and the pediatrician reported the parents never missed a medical appointment. The SM had complications during her pregnancy, including poor fetal growth, high blood pressure and was positive for Group B Strep. The SC had rapid breathing and was jaundiced at birth but had no ongoing medical conditions.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062988 - Deceased Child, Female, 2 Mons	062989 - Mother, Female, 18 Year(s)	DOA / Fatality	Substantiated
062988 - Deceased Child, Female, 2 Mons	062989 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Substantiated
062988 - Deceased Child, Female, 2 Mons	062990 - Father, Male, 21 Year(s)	DOA / Fatality	Substantiated
062988 - Deceased Child, Female, 2 Mons	062990 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
062988 - Deceased Child, Female, 2 Mons	062991 - Grandparent, Female, 67 Year(s)	DOA / Fatality	Unsubstantiated
062988 - Deceased Child, Female, 2 Mons	062991 - Grandparent, Female, 67 Year(s)	Inadequate Guardianship	Unsubstantiated
062988 - Deceased Child, Female, 2 Mons	062991 - Grandparent, Female, 67 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
062988 - Deceased Child, Female, 2 Mons	062989 - Mother, Female, 18 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
062988 - Deceased Child, Female, 2 Mons	062990 - Father, Male, 21 Year(s)	Lacerations / Bruises / Welts	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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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 offered bereavement services to the mother and father, and made a referral to a mental health counselor on behalf of the father. OCDSS offered funeral assistance, but the family refused. OCDSS discussed DV services with the mother due to concern regarding the father being verbally abusive, which the mother refused.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the mother and father; however, they were not engaged at the time the CPS investigation closed. OCDSS made a referral to mental health counseling on behalf of the father but he had not yet scheduled an appointment. The mother had a counselor established prior to the subject child's death, and planned to reengage in counseling.

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? N/A
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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☐ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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 is 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