Child Fatality Report

Report Identification Number: AL-23-006

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

Issue Date: Jul 24, 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 **Jurisdiction:** Montgomery **Date of Death:** 02/10/2023
Age: 4 month(s) **Gender:** Male **Initial Date OCFS Notified:** 02/10/2023

Presenting Information

The SCR report alleged that the grandmother fed the subject child around 1:30AM and then placed him facing up with pillows around him and next to her in the same bed. At 7:00AM, the grandmother woke to find the child face down and not breathing. 911 was called and the grandmother performed cardiopulmonary resuscitation (CPR) until emergency medical services (EMS) arrived. EMS continued CPR on the way to the hospital. The child was pronounced deceased at the hospital. It was believed the unsafe sleeping conditions contributed to the death. The condition of the home was concerning as there were piles of garbage 5ft high. Space heaters were used to heat the inside and under the home. There were no clean surfaces to prepare food and multiple bottles of medications were left out in sight. None of the adults in the home were addressing the condition of the home.

Executive Summary

This report concerns the death of the 4-month-old subject child. Montgomery County Department of Social Services (MCDSS) received an SCR report regarding the child's death on 2/10/23. At the time of his death, the child resided with his mother and 2-year-old sibling. They were temporarily staying in the maternal grandmother's home, where a cousin and the cousin's paramour also resided. The subject child's father resided in a separate residence.

On 2/9/23, the mother, grandmother, sibling, and subject child returned home around 4:30PM from being out of the house all day. The mother attempted to put the subject child down for a nap; however, he would not fall asleep. The grandmother tried by patting his bottom and laying in bed with him, and the child fell asleep. He woke up between 7:30 or 8:00PM, at which time the grandmother fed him, burped him, changed his diaper, applied cream for a rash, and placed him back to sleep. He woke again around 1:30AM, had a bottle, and played for approximately one hour before falling back asleep. The grandmother's alarm went off at 7:00AM, she got up, turned the alarm off, and started to get ready. She noticed the child was face down on the bed. Figuring he had just rolled over, she picked him up and realized he was not breathing. The grandmother told the cousin to call 911. The 911 dispatcher instructed the grandmother on how to perform CPR until law enforcement and EMS arrived and took over life saving measures. The child was transported to the hospital where he was pronounced deceased.

The mother, sibling, and subject child had been residing in the maternal grandmother's home about one week. Although the sibling had a crib, the subject child had no safe sleep provisions, and it was routine for him to sleep in bed with the grandmother. The mother also routinely co-slept with the child, stating the child was never alone on the bed, and would have a towel twisted up and wrapped around him like a cradle. The mother explained a nurse at the birthing hospital told her how to do this.

The medical examiner was notified of the death and performed an autopsy. The cause of death was undetermined; however, noted "history of infant co-sleeping with an adult." The manner of death was also undetermined. No signs of trauma, broken bones, or injuries were noted. Law enforcement had not made any arrests and their investigation was pending.

MCDSS made several home visits and interviewed all adults present during the fatal incident, as well as the mother and father. The sibling was routinely assessed throughout the investigation. MCDSS initially made a safety plan with the parents in which the sibling stayed at a family resource's house until MCDSS could gather more information regarding the fatality and the cleanliness of the residence could be addressed. MCDSS reassessed the plan and upon the mother

relocating to a new home, the sibling was able to return to her mother and father's respective residences.

At the time this fatality report was written, MCDSS had not yet determined the allegations and the CPS investigation remained ongoing.

PIP Requirement
For citations identified in historical cases, Fulton County DSS will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify action(s) FCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, FCDSS will review the plan and revise as needed to address ongoing concerns.

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?** — N/A
- **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

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 case remained open at the time this fatality report was written. As a determination of the allegations had not yet been made, the safety decision due at the time of determination was not due.

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: 02/10/2023 **Time of Death:** 08:07 AM

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

County where fatality incident occurred: Montgomery
Was 911 or local emergency number called? Yes
Time of Call: 07:03 AM
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	Male	4 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	46 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Other Adult - Cousin's paramour	Alleged Perpetrator	Male	18 Year(s)
Deceased Child's Household	Other Adult - Cousin	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Father	No Role	Male	26 Year(s)

LDSS Response

On 2/10/23, MCDSS received a report regarding the death of the subject child. MCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. MCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the district attorney of the fatality. MCDSS assessed the safety of the surviving sibling and conducted home visits to the required residences the same day.

MCDSS interviewed all adults regarding the events leading up to the child’s death. The mother and father had recently split up and the mother moved into the MGM’s home with the subject child and surviving sibling about a week ago. The mother reported during the day of 2/9/23, the child had been teething and the mother was administering Motrin, as she said was advised by the pediatrician. MCDSS learned from the child’s pediatrician that the child was seen 2/7/23, received his

required immunizations, and was prescribed a cream for a rash; however, the pediatrician denied the mother was counseled to provide Motrin, as that was not recommended based on the child's age. The mother recalled the child was irritable that evening and had gone to sleep around 7:00 or 7:30PM and slept in the MGM's room. The mother said she went to sleep around 8:30PM. The mother next woke on 2/10/23 at 4:00AM and went to work. At 8:00AM the mother was notified by her supervisor there was an emergency with the child. The MGM confirmed she put the subject child to bed the evening of 2/9/23, which was their routine. She typically put him to bed between 7:00 and 8:00PM. The child slept in MGM's bed, with a blanket tucked underneath his arms, and MGM slept in the bed as well. As is normal, the child woke around 1:30AM, MGM fed him a bottle, burped him, he played a little while, then went back to sleep about 2:30AM. MGM next woke to her alarm at 7:00AM. MGM observed the child face down on the bed. Figuring he rolled himself over, MGM went to pick him up and realized he was not breathing. MGM called to the cousin who resided in the home and told her to call 911. The MGM administered CPR as instructed by the dispatcher until law enforcement arrived and took over. The child was taken by ambulance to the hospital. The cousin confirmed the MGM's account of events, adding that the mother had asked the cousin to watch the sibling so the mother could go to a friend's house, which the cousin agreed to. The cousin heard the MGM yelling to her to call 911, which she did. The cousin's paramour resided in the home and was awoken to the MGM's yelling and had no further information. All three adults confirmed the mother was not home during the overnight and had left to a friend's house, contrary to the mother's account. The father was interviewed; however, had no additional information regarding the fatality.

The MGM's home was observed to be dirty, with several bags of garbage piled up and no place for the children to play. Multiple space heaters were being used to heat the home, as well as the pipes underneath the home. The physical condition of the home was deemed unsafe for the sibling to continue residing there and a safety plan was developed with the parents in which the sibling would reside with a relative until the mother was able to secure suitable housing. The sibling's safety was assessed at the relative resource's home on 2/10/23.

MCDSS reached out to the ME with information gathered during the investigation, specifically concerning the use of Motrin. Services specific to the fatality were offered to the mother, father, and MGM, although no one had engaged in services at the time this report was written. The mother secured her own housing, the mother and father's respective residences were assessed, and the sibling was deemed safe with either parent and returned on 2/24/23. MCDSS continued to monitor the sibling's safety and well-being as the CPS investigation remained open.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

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? No
Comments: Montgomery 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
063537 - Deceased Child, Male, 4 Mons	063884 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Pending

063537 - Deceased Child, Male, 4 Mons	063885 - Grandparent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063537 - Deceased Child, Male, 4 Mons	063886 - Other Adult - Cousin's paramour, Male, 18 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063537 - Deceased Child, Male, 4 Mons	063887 - Other Adult - Cousin, Female, 19 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063537 - Deceased Child, Male, 4 Mons	063885 - Grandparent, Female, 46 Year(s)	DOA / Fatality	Pending
063537 - Deceased Child, Male, 4 Mons	063885 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Pending
063883 - Sibling, Female, 2 Year(s)	063884 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063883 - Sibling, Female, 2 Year(s)	063885 - Grandparent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063883 - Sibling, Female, 2 Year(s)	063886 - Other Adult - Cousin's paramour, Male, 18 Year(s)	Inadequate Food / Clothing / Shelter	Pending
063883 - Sibling, Female, 2 Year(s)	063887 - Other Adult - Cousin, Female, 19 Year(s)	Inadequate Food / Clothing / Shelter	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:

Records were requested from the treating hospital, law enforcement, and EMS; however, the record did not reflect if they were received and reviewed.

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:
The MGM’s residence was assessed to be unsafe for the sibling to continue residing. The parents and MCDSS planned for the sibling to reside at a relative’s home until safety concerns could be adequately addressed. The RAP had not yet been completed at the time this report was written.

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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	☐	☒	☐	☐	☐	☐	☐
Other, specify: Preventive Services							

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? No
Explain:
The surviving sibling was 2-years-old and a services need specific to the fatality was not identified; however, the parents were provided with bereavement and counseling information.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Counseling services were offered to the mother, father, and maternal grandmother. It was unknown if they engaged in services at the time this fatality report was written.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used prescription drugs
- ☐ Used marijuana
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/25/2020	Sibling, Female, 1 Days	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report was received by Fulton County Department of Social Services (FCDSS) on 9/25/20, which said the mother had given birth to the sibling. The mother previously had two other CHN removed from her care. An ADD INFO was received 9/26/20 which said that the father passed out, hit his face, and went to the emergency room. The father tested positive for marijuana. A subsequent report was received 10/12/20 which stated the sibling was born with Ventral Septal Defect and required a higher level of care. At the hospital, the mother was not feeding the sibling on demand and was laying the sibling on her side to sleep with a blanket over the sibling's face.

Report Determination: Unfounded | **Date of Determination:** 01/27/2021

Basis for Determination:
FCDSS found a lack of credible evidence to substantiate the allegations in the reports. The mother denied the allegations and demonstrated an understanding of safe sleep and on several unannounced home visits, the mother was found to be practicing safe sleep with the sibling. The sibling was observed by FCDSS to be of adequate height and weight and collateral contacts revealed no concerns for the sibling at the time the CPS investigation was closed.

OCFS Review Results:
FCDSS initiated their investigation timely and contacted the sources of the reports. FCDSS followed up on concerns noted in the additional information report. FCDSS ensured the mother had adequate provisions for the newborn sibling, addressed safe sleep, and ensured the mother knew how to properly swaddle the sibling. FCDSS contacted family collaterals; however, did not document coordination with MCDSS regarding the mother's progress in the open services

case which involved the two children removed from her care previously, part of the allegation contained in the SCR report.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There were missed opportunities to gather collateral information. The mother had two children previously removed from her care and who remained out of her care during the open CPS investigation with FCDSS. The mother was on an open services case with MCDSS and the record did not reflect conversations or coordination with MCDSS.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
FCDSS will make diligent efforts to contact collaterals to potentially gather outside information and relevant information as it pertain to safety and risk.

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

The mother had prior CPS history regarding two children who were removed from her care. These children were freed for adoption and were not a part of the subject child's household, therefore, their history is not included in this report.

The grandmother had prior CPS history, including an indicated report for Educational Neglect.

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