Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-23-010

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

Issue Date: Aug 18, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Fulton
Gender: Female
Date of Death: 04/25/2023
Initial Date OCFS Notified: 04/25/2023

Presenting Information

An SCR report alleged that on 4/24/23 at approximately 11:00 PM, the parents put the 1-month-old female subject child to sleep in her bassinet. On 4/25/23 at 4:40 AM, the mother checked on the child and found her to be blue, not breathing, and unresponsive. The parents called 911 at 4:48 AM and attempted to perform cardiopulmonary resuscitation. Emergency medical services responded to the home and took over resuscitation efforts. The child was transported to the hospital and pronounced deceased. The child was otherwise healthy and the parents did not have an explanation for her death. A subsequent report was received that alleged concerns about the parents co-sleeping with the child.

Executive Summary

On 4/25/23, the Fulton County Department of Social Services (FCDSS) received an SCR report regarding the death of the 1-month-old female subject child. The report alleged DOA/Fatality and Inadequate Guardianship against the mother and father. The child lived with her parents and there were no surviving siblings or other children residing in the home.

Through a joint investigation with law enforcement, it was learned that on 4/24/23 around 11:00 PM, the mother fed the child and then placed her to sleep on her back in a bassinet next to the parents' bed. On 4/25/23 at approximately 4:45 AM, the mother woke up and picked the child up. The child's body felt heavy and she was not breathing. The mother called the grandmother on the phone, who instructed the mother to hang up and call 911. The mother called 911 and the father attempted cardiopulmonary resuscitation. First responders arrived at the home, took over life-saving efforts, and transported the child to the hospital. Resuscitative efforts were unsuccessful and the child was pronounced deceased upon arrival to the hospital.

An autopsy was performed and the final results were pending further studies. The coroner reported that there were no signs of child abuse or neglect and that the death was believed to be medical in nature. Law enforcement conducted an investigation and completed an assessment of the home, which the parents consented to. Following their search of both the bed and bassinet, they were unable to find anything that would have led them to believe that the child had been mistreated or abused. The bassinet had a fitted sheet covering the padded bottom. On the far-left side of the bassinet were multiple items tucked up against the side, including pacifiers, baby oil, baby lotion, a bottle, a baby brush, and an infant hat. These items were where the child's feet were reported to have been. The search of the apartment did not identify anything that would have been indicative of foul play. Law enforcement's investigation was pending closure upon receipt of the final autopsy.

FCDSS offered the parents information on grief counseling, funeral assistance, and mental health counseling. It was unknown if the parents accepted the services offered. FCDSS unsubstantiated the allegations against the parents, as they determined there was not a fair preponderance of evidence in relation to the allegations in the report. FCDSS supported their determination by stating the evidence gathered through casework and collateral contacts did not give cause to suspect that the parents' actions or inactions contributed to the child's death and there was no evidence to suspect that the parents failed to provide a minimum standard of care for the child within societal norms. The CPS investigation was unfounded and closed on 6/23/23.

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:
The completion of the safety assessment tools was not required as there were no surviving children. A determination was made in congruence with the evidence gathered 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:
The closure of the CPS investigation was appropriate, as all required casework activity was completed and there were no surviving children in the home.

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: 04/25/2023 **Time of Death:** 05:05 AM

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

County where fatality incident occurred: Fulton

Was 911 or local emergency number called? Yes

Time of Call: 04:48 AM

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A

Child's activity at time of incident:

- ☒ 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)

LDSS Response

Upon receipt of the SCR reports on 4/25/23, FCDSS coordinated efforts with law enforcement, notified the district attorney and the coroner, spoke with medical collaterals, completed interviews with the family, and offered services related to the fatality.

FCDSS completed a home visit and requested to interview the parents separately, which the parents agreed to. The mother reported nothing abnormal occurred in the days leading up to the death. The mother stayed home with the child and the father worked. The mother fed and changed the child and they napped periodically. The mother reported the child was very fussy, which she believed to be gas and did not feel was abnormal for the child. On 4/24/23 between 11:00 PM and 11:30 PM, the mother fed the child and then placed her to sleep in a bassinet next to the parents' bed. On 4/25/23, the mother woke up at 4:45 AM and found it strange the child was still asleep, as it was typical for the child to wake prior to that time for a feeding. The mother picked the child up and she felt heavy and could not wake her. The mother reported she was not registering what was happening and called the grandmother to ask her how to wake the child up. The grandmother told the mother to get off the phone and call 911, which the mother did.

FCDSS interviewed the father who stated it was typical for the mother to wake up with the child, as he worked long hours and was exhausted. The father reported in the days leading up to the death the parents were giving the child gripe water for gas, but other than that the child was acting normally. On 4/24/23, the father went to sleep between 7:00 PM and 8:00 PM. The father woke sometime around midnight, and the mother was awake and changing the child. The father was woken by the mother around 4:45 AM, stating she could not wake the child up. The father began CPR until first responders arrived and transported the child to the hospital.

FCDSS inquired about safe sleep and substance abuse. The parents reported smoking marijuana but that there was always a sober caretaker for the child and denied smoking the night prior to the death. The parents stated they understood safe sleep guidelines and advised they were practicing safe sleep. Both parents reported that the mother had fallen asleep with the child in bed with her at the very beginning of the child's life, but they changed their routine to assure the mother stayed awake and put the child back in the bassinet to sleep. On the night of the incident, the child slept on her back in the bassinet in a nightgown with an elastic bottom. The child's head was toward the parents' bed and a couple of diapers and wipes were at the other end of the bassinet for easier access. The father stated the child's pacifier was in the bassinet as

well, but denied there were any other items or blankets.

FCDSS spoke to the grandmother who confirmed the mother called her when the child would not wake up. The grandmother advised the mother to hang up and call 911 and then left to go to the family's apartment. First responders were arriving as the grandmother got to the home, approximately three minutes after speaking with the mother. The grandmother expressed no concerns for the parents' care of the child, nor did she have any concerns about the parents in relation to substance abuse, domestic violence, and co-sleeping.

FCDSS spoke to the pediatrician's office, who expressed no concerns about abuse or neglect by the parents. The parents kept scheduled appointments, were appropriate with the child during office visits, and appeared well-bonded with the child.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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?No
Comments: Fulton 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
064589 - Deceased Child, Female, 1 Mons	064590 - Mother, Female, 18 Year(s)	DOA / Fatality	Unsubstantiated
064589 - Deceased Child, Female, 1 Mons	064590 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
064589 - Deceased Child, Female, 1 Mons	064591 - Father, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated
064589 - Deceased Child, Female, 1 Mons	064591 - Father, Male, 21 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐

Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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
- ☐ 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 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