Report Identification Number: AL-23-013

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

Issue Date: Dec 11, 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:** Rensselaer **Date of Death:** 07/07/2023
Age: 3 year(s) **Gender:** Female **Initial Date OCFS Notified:** 07/07/2023

Presenting Information

An SCR report was received and alleged that on 7/6/23 at an unknown time, the mother put the 3-year-old female subject child to sleep in her bedroom. On the morning of 7/7/23, the mother checked on the child and observed her to be unresponsive and foaming at the mouth. The mother called 911 and emergency medical services arrived at the home, initiated life-saving measures, and transported the child to the hospital. The subject child was pronounced deceased at 8:13 AM. The child was otherwise healthy, and the mother and mother's partner had no explanation for her death. On 9/14/23, another SCR report was received regarding the death. The report contained additional concerns regarding drug abuse, drug sales, prostitution, and the child having a positive toxicology at the time of her death.

Executive Summary

On 7/7/23, the Rensselaer County Department of Social Services (RCDSS) received an SCR report regarding the death of the 3-year-old subject child. Duplicate reports were received on 7/7/23 and 7/14/23 and merged with the initial investigation. The reports alleged DOA/Fatality and Inadequate Guardianship against the mother and the mother's partner. On 9/14/23, another report was received by the SCR regarding the death. Additional allegations of Sexual Abuse, Lacerations/Bruises/Welts, Choking /Twisting/Shaking, Parent's Drug Alcohol Misuse, and Poisoning/Noxious Substances were alleged.

The child lived with her mother, and the mother's partner had moved into the home a week before the child's death. The child's father had sporadic contact with the child due to his out-of-state travel for his employment. There were no surviving minor siblings or other children residing in the home.

Through a joint investigation with law enforcement, it was learned that a week before the child's death, the mother met her partner for the first time outside of her apartment. The mother allowed her partner to assist her in carrying groceries inside, which initiated their relationship and his moving into the home. The night before the death, the mother left the child in the care of her partner while she went grocery shopping. The mother returned to the apartment to put the groceries away and the child was awake at that time. The mother left the home again to purchase cigarettes, and upon her return, the mother's partner said the child had gone to sleep. The mother looked into the bedroom and saw the child was asleep on her bed. The mother stayed up with her partner until approximately 11:30 PM, when she took medication and then immediately fell asleep as a result. During the night, the mother woke up and observed her partner asleep on the recliner without clothing on. The mother got up and placed a blanket over him to avoid the child seeing him naked. The mother went back to sleep. In the morning, the mother woke up and went to check on the child. The child was unresponsive, cold, and had foam coming out of her mouth. The mother called 911 and the first responders were at the home within minutes. The child was transported to the hospital where she was pronounced deceased.

An autopsy was performed and the final results were pending the toxicology. Due to the ongoing criminal investigation, the report would not be shared with RCDSS once completed. Law enforcement conducted an investigation and the mother's partner was arrested in relation to the death of the child. The mother's partner was charged with rape and murder. The criminal court proceedings were ongoing at the time the CPS investigation closed.

The allegations of Inadequate Guardianship, DOA/Fatality, and Sexual Abuse against the mother's partner were substantiated as he was charged criminally with the rape and death of the child. The mother was substantiated for Inadequate Guardianship as RCDSS determined that the mother failed to meet a minimum standard of care for the child

when she left the child in the care of the mother's partner, a man she had just met and knew nothing about. The mother's actions resulted in a significant risk to the child's physical, mental, and emotional well-being. DOA/Fatality against the mother was unsubstantiated. Due to the ongoing criminal investigation, RCDSS was not able to obtain police reports, autopsy results, or interview the mother's partner, resulting in a lack of a fair preponderance of evidence to substantiate the allegations Lacerations/Bruises/Welts, Parent's Drug Alcohol Misuse, and Poisoning/ Noxious Substances against the mother and the mother's partner.

RCDSS offered the mother and father information on grief and mental health counseling and funeral assistance. The initial CPS investigation was indicated and closed on 9/20/23 and the 9/14/23 investigation was indicated and closed on 9/29/23.

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: 07/07/2023 **Time of Death:** 08:13 AM

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

County where fatality incident occurred: Rensselaer
Was 911 or local emergency number called? Yes
Time of Call: 07:18 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

- [ ] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [x] 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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	33 Year(s)

LDSS Response

RCDSS received the SCR report regarding the death on 7/7/23 and initiated their investigation. RCDSS interviewed the mother who reported the relationship with her partner started on 7/1/23, after she encountered him outside of her apartment and he offered to carry her groceries inside. The child was staying with a family friend from 7/1/23 through 7/5/23, when she returned home and met the mother's partner for the first time. On 7/6/23, the child spent the day at daycare and returned home around 4:30 PM. The mother and a friend made a decided to go grocery shopping at 7:00 PM. The mother left and the child stayed home with the mother's partner. The mother returned home from shopping around 8:30 PM. The child was awake and playing with her toys in the living room. The mother left the home again at 9:00 PM to buy cigarettes and returned 30 minutes later. Upon her return, the mother's partner was in the living room and reported he was able to get the child to bed. The mother found this to be unusual, as typically it was difficult to get the child to go to sleep. The mother looked in on the child in her bedroom and saw her asleep on her bed underneath the covers. The mother fell asleep on the couch around 11:30 PM and reported her partner went to sleep at 2:30 AM, as that was the last time he used her phone to send a text. The mother reported waking in the night and her partner was naked and asleep on the recliner. The mother covered him up and went back to sleep. On 7/7/23 at 7:00 AM, the mother checked on the child and found her unresponsive. The mother screamed for her partner to call 911 and he did not. The mother called 911 and they responded within minutes. The mother recalled that after first responders had arrived, her partner told her they could have another baby together, which upset her. During the incident, the mother's partner became irate and was eventually restrained and

arrested. When questioned about substance use and sales in the home, the mother reported she had one drink on 7/6/23 and her partner was drinking beers and smoking marijuana.

RCDSS was informed by law enforcement that the mother's partner's attorney asked for a gag order and CPS was not allowed to interview him. RCDSS interviewed the father who reported that he often was out of state due to traveling for work. The father last had contact with the child in April 2023. The father had no safety concerns for the child in the mother's care. The father was aware the mother spoke to other men but did not meet the mother's partner nor was he aware that the mother's partner was living in the home. RCDSS spoke to the friend who ran errands with the mother, and she provided a similar account of events regarding the times the mother was out of the house. In addition, RCDSS interviewed the family friend with whom the child was staying with prior to the death. The friend reported the mother would leave the child in her care for long periods of time and the friend had concerns about who the mother would use for childcare.

RCDSS gathered information from first responders who received a call regarding the 3-year-old being unresponsive at the home. Upon their arrival, the child remained in the bed on her back with her arms by her side. The child's room smelled like bleach, which the mother reported was due to her use of Clorox wipes. Rigor mortis had not set in, but the child was cold to the touch and did not have a pulse. Though it was believed the child was already deceased, CPR was initiated. The child was transported to the hospital. The mother told first responders she last saw the child alive at 8:30 PM the night prior. The mother was distraught, and the mother's partner was quiet. There were no signs of substances in the home and the mother and her partner did not appear under the influence. RCDSS spoke to the daycare provider and pediatrician, who reported no concerns for the child.

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

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
065288 - Deceased Child, Female, 3 Yrs	065290 - Mother's Partner, Male, 33 Year(s)	DOA / Fatality	Substantiated
065288 - Deceased Child, Female, 3 Yrs	065290 - Mother's Partner, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
065288 - Deceased Child, Female, 3 Yrs	065290 - Mother's Partner, Male, 33 Year(s)	Sexual Abuse	Substantiated
065288 - Deceased Child, Female, 3 Yrs	065289 - Mother, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated
065288 - Deceased Child, Female, 3 Yrs	065289 - Mother, Female, 43 Year(s)	Inadequate Guardianship	Substantiated

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:

RCDSS was not permitted to speak with the mother's partner due to ongoing criminal proceedings.

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?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2

Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/02/2023	Mother's partner	Pending	Unknown
Comments:	As a a result of the child's death, the mother's partner was charged with murder in the second degree.		

Criminal Charge: Rape **Degree:** 1

Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**

08/02/2023	Mother's partner	Pending	Unknown
Comments:	As a result of the child's death, the mother's partner was charged with rape in the first degree.		

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:
The mother declined services offered by RCDSS; however, was enrolled in services provided through a community agency.

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

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

In 2014, the mother had an unfounded CPS investigation, including an unsubstantiated allegation of Inadequate Guardianship, regarding her now adult son and two nephews.

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