Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-23-019

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

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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:** 10/11/2023
Age: 4 month(s) **Gender:** Female **Initial Date OCFS Notified:** 10/11/2023

Presenting Information

On 10/11/2023, Rensselaer County Department of Social Services (RCDSS) received an SCR report which alleged on the same date the mother (SM) fed the 4-month-old child (SC) and fell asleep. The mother awoke an hour later, and the child was unresponsive and bluish in color. The mother called 911 and initiated CPR until first responders arrived. The child was transported to the hospital by ambulance where she was pronounced dead. It was believed the unsafe sleep environment contributed to the child's death. A subsequent report was received on the same date which contained additional allegations against the mother and father (SF) regarding the deplorable condition of the home. The role of the adult cousin (OA) was unknown.

Executive Summary

This report concerns the death of a 4-month-old child which occurred while in the care of her mother. The mother breast fed the child on the living room couch at approximately 12:00 AM and fell asleep while doing so. The adult cousin entered the living room and found the child unresponsive, alerted the mother and father and called 911. The child was transported to the hospital by ambulance where she was pronounced dead.

RCDSS interviewed the mother, father, and adult cousin. All confirmed the mother had fed the child and fell asleep on the living room couch while feeding her. It was unclear from interviews which position the cousin found the mother and child in. There was a subsequent SCR report which alleged the home was in deplorable conditions. RCDSS stated in the case record the home met minimal standards during all home visits to the address.

Law enforcement investigating the child's death were interviewed by RCDSS. Law enforcement stated an autopsy was performed and the cause of death was identified as accidental asphyxiation. Law enforcement did not pursue criminal charges against the mother.

Allegations against the mother regarding the death of the child were substantiated. Additional allegations regarding the deplorable condition of the home were unsubstantiated. Services in relation to the death of the child were offered to the family by RCDSS and accepted. The mother identified she would also utilize existing service providers and the investigation was closed.

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** Yes, sufficient information was

allegations as well as any others identified in the course of the investigation?	gathered to determine all allegations.
• **Was the determination made by the district to unfound or indicate appropriate?**	Yes

Explain:
The decision to close the case was made commensurate with the case circumstances and a determination of the allegations was made in congruence with the evidence gathered.

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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case 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: 10/11/2023 **Time of Death:** 01:55 AM

Time of fatal incident, if different than time of death: 01:00 AM

County where fatality incident occurred:	Rensselaer
Was 911 or local emergency number called?	Yes
Time of Call:	01:07 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:

☒ 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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	42 Year(s)
Deceased Child's Household	Other Adult - Cousin	No Role	Male	18 Year(s)

LDSS Response

RCDSS received the SCR report and coordinated their response with LE. LE informed RCDSS the OA discovered the SC and SM asleep on the couch. The SM stated to them she remembered breast feeding the SC, though did not remember falling asleep. The SM and SF awoke to the OA yelling at the SM to wake up.

RCDSS interviewed the SM, SF, and OA in the home. The SM stated she fed the SC on the couch in the living room at approximately 12:00 AM. The SM stated she must have fallen asleep feeding the SC as she did not remember anything else until the OA yelled for her to wake up. The SF stated he fell asleep in the bedroom at approximately 9:00 PM and woke when he heard the OA yell for help. The OA stated he had been watching a movie in his bedroom and entered the living room. The OA saw the SM and SC on the couch and did not think the SC was breathing. It was unclear from the case record what position the OA found the SM and SC in. The OA attempted to wake the SC, yelled at the SM and SF to wake up, then called 911 while the SM performed CPR. The SM and SF stated the SC usually slept in the car carrier or a bassinet which was observed in the bedroom. RCDSS observed the home to meet minimal standards during their visits to the address despite reported concerns for the deplorable condition of the home.

RCDSS obtained the SC's medical records from their pediatrician. The SC was born with a positive toxicology to the SM's medications and admitted to the NICU. There was an additional concern for the SC losing weight as a newborn, though that was no longer a concern at the time of her death. There were no additional medical concerns identified for the SC in the care of the SM and SF at the time of her death.

RCDSS interviewed LE investigating the fatal incident. LE stated an autopsy was completed and the preliminary cause of death was accidental asphyxiation. The SM was sober prior to the fatal incident and there were no signs of abuse or trauma present in the SC. The final autopsy report became available before RCDSS closed their investigation. There were no additional diagnoses made and the cause of death was confirmed as accidental asphyxiation. LE stated they would not be pursuing criminal charges.

The allegations of DOA/Fatality and IG against the SM regarding the SC were substantiated. Allegations of IF/C/S against the SM and the SF regarding the condition of the home were unsubstantiated. RCDSS offered services to all household members in relation to the death of the SC. The SM accepted grief services and stated she would utilize existing providers. Additional services were declined by other household members.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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? Yes
Comments: The fatality was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066488 - Deceased Child, Female, 4 Month(s)	066489 - Mother, Female, 42 Year(s)	DOA / Fatality	Substantiated
066488 - Deceased Child, Female, 4 Month(s)	066489 - Mother, Female, 42 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066488 - Deceased Child, Female, 4 Month(s)	066489 - Mother, Female, 42 Year(s)	Inadequate Guardianship	Substantiated
066488 - Deceased Child, Female, 4 Month(s)	066490 - Father, Male, 47 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066488 - Deceased Child, Female, 4 Month(s)	066490 - Father, Male, 47 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Services in relation to the death of the SC were accepted by the SM. The SM also participating in services through existing providers.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Funeral assistance was provided following the death of the child. Further services in relation to the death of the child were accepted, and the SM utilized preexisting service providers.

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

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

The SM had 10 CPS investigations dating back to June of 2000 with common allegations of PD/AM and LS concerning her now adult child. Nine of the investigations had allegations which were substantiated.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A prevention services case was opened in March 2007 and provided the SM with parenting skills, addressed behaviors the now adult child displayed in school, and supported the SM's mental health. Prevention services were closed in May 2008.

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