Child Fatality Report

Report Identification Number: AL-24-003

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

Issue Date: Jun 10, 2024

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: Schenectady
Gender: Female
Date of Death: 01/27/2024
Initial Date OCFS Notified: 01/27/2024

Presenting Information

An SCR report alleged that on 1/27/24 at 1:00AM, the mother and father fed the 1-month-old female subject child and placed her to sleep in her bassinet. The father checked on the child shortly after, then again at 2:00AM, and had no concerns. The mother woke up at 9:26AM and checked on the child. The child was not breathing and was blue. The mother called 911 and first responders arrived and transported the child to the hospital. Despite further attempted lifesaving measures the child was pronounced deceased at the hospital. The child was otherwise healthy and the parents did not have an explanation for the death. In addition, the uncle and friend who resided in the home did not have an explanation for the death.

Executive Summary

On 1/27/24, the Schenectady County Department of Social Services (SCDSS) 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, father, uncle, and a friend who resided in the home. In addition to the adults, there was a 4-year-old sibling who lived in the home part-time, as the father had shared custody with that child's mother.

Through a joint investigation with law enforcement, it was learned that on the evening of 1/26/24, the child was at home with the mother, father, uncle, friend, and sibling. The family ate dinner together and then went into their bedrooms around 10:00PM. The family returned to the kitchen for a snack an hour later, before going to their bedrooms for the remainder of the evening. On 1/27/24, the mother fed the child at 12:30AM, held her for twenty minutes, then placed her to sleep on her back in a bassinet. The mother fell asleep and then the father. At 2:00AM, the father woke up, fed and burped the child, then placed her back in the bassinet. The child was fussing, so the father placed the child in the bed for approximately ten minutes, before putting her back in the bassinet. The father denied falling asleep with the child and denied the parents ever co-slept. At 9:00AM, the mother woke up and discovered the child in the bassinet unresponsive. 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 at the hospital.

An autopsy was performed and the cause of death was sudden infant death syndrome (SIDS) and the manner was natural. Collateral contacts had no concerns for the parents' care of the child. There was no concern for abuse or maltreatment. The parents were observed to respond appropriately and did not present as impaired. The child's toxicology was negative for drugs and alcohol. Law enforcement's investigation was closed without criminal charges against the adults.

SCDSS offered the family information on grief counseling, funeral assistance, and daycare assistance; though it was unknown if the family utilized these services. SCDSS provided temporary housing when the family's home was seized for law enforcement's criminal investigation. SCDSS unsubstantiated the allegations against the adults, as they determined there was not a fair preponderance of evidence in relation to the allegations in the report. SCDSS supported their determination by summarizing how the evidence gathered through casework and collateral contacts did not give cause to suspect that the actions or inactions of the adults contributed to the child's death. The CPS investigation was unfounded and closed on 3/22/24.

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?** Yes
- **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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 commensurate with 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: 01/27/2024 **Time of Death:** 10:17 AM

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

County where fatality incident occurred: Schenectady
Was 911 or local emergency number called? Yes
Time of Call: 09:27 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	Aunt/Uncle	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Other Adult - Friend	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

Upon receipt of the SCR report on 1/27/24, SCDSS coordinated efforts with law enforcement, notified the district attorney and the medical examiner, spoke with medical collaterals, completed interviews with the family, and offered services related to the fatality.

SCDSS interviewed the mother who reported on 1/26/24, the family cooked dinner, then watched a movie in the bedroom. Around 11:00PM, everyone went in the kitchen to make a snack and they hung out for a little while before returning to their bedrooms. The mother fed the child on 1/27/24 at 12:30AM, then held the child for about 20 minutes before placing her to sleep in her bassinet. The mother fell asleep and woke up around 9:00AM. The mother walked by the child's bassinet and did not see the child's stomach moving. When she checked on the child, she was cold and unresponsive. The mother contacted 911 and the father began cardiopulmonary resuscitation until the arrival of first responders. The mother reported no medical concerns for the child, and no significant events regarding the child in the days leading up to her death.

SCDSS interviewed the father who stated after falling asleep for the night, he woke up on 1/27/24 at 2:00 AM to feed the child. The mother made two bottles to prepare for the night feedings, and the father retrieved one and fed the child. The father burped the child and placed her to sleep in the bassinet. The child became fussy, so the father laid the child in bed with him, the mother, and the sibling for approximately 10 minutes. The father then placed the child back in the bassinet. The father denied he and the mother co-slept with the child and said the child was only in the bed if the parents were awake. The father initially did not provide the details regarding laying the child in bed during the night, and when questioned about this, reported he was distraught when he provided his initial statement and had gained his composure when he provided the additional details later in the day. The father reported the child had no items in the bassinet other than a small pillow that he said came with the bassinet. At 9:00AM, the father was alerted by the mother regarding the child's condition and assisted with cardiopulmonary resuscitation.

The uncle and friend were interviewed and denied having a caretaking role for the child. They expressed no concerns regarding the child's care. The uncle reported the marijuana found in the home belonged to him. Other familial collaterals were interviewed and denied concerns for the care of the child and denied that the parents co-slept with the child. SCDSS documented efforts to interview the sibling, though he would not engage with the interview process. His safety was otherwise assessed, and he was determined to be safe in the care of the father and his mother.

SCDSS received information from the sibling's mother, in which she stated that the father called her several hours before contacting 911 expressing concern for the child's condition. Law enforcement investigated the allegation, including a review of phone records, and found no evidence to support this. There were additional concerns regarding the temperature of the home being too warm and a photo was discovered of the child sleeping in the bed with the parents on the night of the death. The father reported being awake, taking the photo, and then the child was placed to sleep in her bassinet shortly after. The parents reported the temperature of the home was typical for the family, as they did not like to be cold. The medical examiner reported these factors did not change the final cause of death.

SCDSS spoke to the pediatrician's office, who reported the child was seen at the office on 1/2/24 for her first visit. The child was found to be in good health and there were no concerns noted.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
067291 - Deceased Child, Female, 1 Month(s)	067296 - Other Adult - Friend, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
067291 - Deceased Child, Female, 1 Month(s)	067296 - Other Adult - Friend, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
067291 - Deceased Child, Female, 1 Month(s)	067292 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
067291 - Deceased Child, Female, 1 Month(s)	067292 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
067291 - Deceased Child, Female, 1 Month(s)	067293 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated
067291 - Deceased Child, Female, 1 Month(s)	067293 - Father, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
067291 - Deceased Child, Female, 1 Month(s)	067295 - Aunt/Uncle, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated

067291 - Deceased Child, Female, 1 Month(s)	067295 - Aunt/Uncle, 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?	☒	☐	☐	☐

Additional information:
SCDSS documented efforts to engage the sibling in an interview but were unsuccessful.

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	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

In 2018, the SF and SS's BM had an indicated CPS investigation with the Administration for Children's Services (ACS) regarding the SS's BM's two other children. The substantiated allegations included Inadequate Guardianship, Lack of Medical Care, and Educational Neglect. The children were removed from their mother's care and placed with a relative.

In 2018, the SF and SS's BM had an indicated CPS investigation with ACS regarding the SS. Inadequate Guardianship was

substantiated because the SS's BM gave birth to the SS while her other children were in foster care, and the SS's BM and the SF had not completed their court-ordered services.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Foster Care Placement History

Between 12/11/18 and 9/9/22, the SF and SS's BM had a foster care case with ACS. The SS's BM had two other children who were removed from her care and placed in relative foster care due to concerns about domestic violence in the presence of those children. The SS's BM completed parenting skills classes, obtained stable housing, completed domestic violence counseling, and participated in ongoing mental health services. The SS's BM's children were returned to her care. The SF was non-compliant. He did not attend court hearings and did not attend services. He had supervised visits with the SS who was born during the services case. The SF no longer resided in the home nor was he in a relationship with the SS's BM.

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