Child Fatality Report

Report Identification Number: AL-22-018

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

Issue Date: Nov 02, 2022

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 has an open 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
Age: 1 month(s)
Jurisdiction: Saratoga
Gender: Female
Date of Death: 05/19/2022
Initial Date OCFS Notified: 05/19/2022

Presenting Information

Saratoga County Department of Social Services (SCDSS) received an SCR report on 5/19/2022 which alleged on the same date between approximately 1:30-1:50 AM, the father (SF) fed the 1-month-old child (SC) a bottle and she fell asleep. The father laid down in the king size adult bed with the child, the already asleep mother (SM) and the 2-year-old sibling (SS). The father then fell asleep sometime after 1:50 AM. The mother awoke at approximately 4:11 AM and saw the father had rolled over on top of the child and she was unresponsive. The father called 911 immediately and the child was transported to the hospital by ambulance where she was pronounced dead at 5:14 AM.

Executive Summary

This report concerns the death of a 1-month-old child which occurred while in the supervision of her father. On 5/19/2022, the father woke at approximately 1:30 AM to feed the child a 4-ounce bottle. The father then placed the child on the adult bed where the mother and 2-year-old sibling were asleep, and he laid between the child and sibling. The mother awoke at approximately 4:11AM and found the father had rolled on top of the child with his shoulder covering her face. The father called 911 and the parents began performing CPR as instructed until first responders arrived and assumed lifesaving attempts.

SCDSS coordinated their investigation with law enforcement. Law enforcement shared pictures of the home from the time of the fatal incident. The photos showed the home to be in deplorable condition with garbage and clothing throughout the home on the floors, and a training toilet in the kitchen filled with urine and feces. SCDSS addressed the condition of the home with the mother and father, and the family moved out of the home during the investigation. Services in relation to the death of the child were declined, though the family accepted voluntary preventive services.

Law enforcement informed SCDSS the preliminary autopsy results identified the cause of death as positional asphyxiation, though the final autopsy report was not available upon the closure of the investigation.

The allegation of DOA/Fatality against the father regarding the 1-month-old child was substantiated. The allegations of Inadequate Guardianship and Inadequate Food, Clothing, Shelter against the mother and the father regarding both children were substantiated due to the condition of the home being a hazard to the health and safety of the children at the time of the fatal incident. The investigation was closed, and a long-term preventive case was opened upon the closure of the investigation.

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? 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:
There was detailed documentation in the case record of supervisory consult throughout the investigation. The family accepted voluntary prevention services and a long-term case was opened.

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: 05/19/2022 **Time of Death:** 05:14 AM

Time of fatal incident, if different than time of death: 01:30 AM

County where fatality incident occurred: Saratoga
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

SCDSS received the SCR report, coordinated their response with LE, and informed the DA and coroner of their involvement with the family. LE informed SCDSS of concerns for the condition of the home and provided SCDSS with photos from the scene showing dirty diapers, clothing, and garbage on the floors throughout the home. A training toilet for the SS was observed in the kitchen to be full of urine and feces and feces was observed to be smeared over the seat. A portable crib was observed in the photos to be full of items and did not appear to be utilized for the SC to sleep in.

SCDSS and LE interviewed the parents. The SF confirmed he fed the SC at approximately 1:30 AM and placed her in the king size adult bed with her head on a fuzzy pillow between he and the SM. The SS was asleep positioned between the SF and the wall. The SF stated he must have fallen asleep and was woken by the SM screaming when she discovered the SC underneath him. The SM confirmed the SF usually wakes up to feed the SC throughout the night so she can sleep. The SM and SF stated it was common for the SS to sleep with them, and sometimes they would transfer him to his toddler bed in his bedroom, but often did not. The SM and SF stated the SC had been spitting up after feedings, and they would watch her after to ensure she did not spit up. The SF stated he put the SC on the bed to ensure she did not spit up, then got in bed with her and fell asleep. A portable crib was observed next to the bed, though SCDSS believed it was not utilized for the SC to sleep in on a regular basis. The parents identified previous knowledge of safe sleep practices and were again counseled on it by SCDSS to ensure the safety of the SS.

The condition of the home was addressed during the investigation. During the initial home visit, the SSs bedroom was observed to have clothing and garbage all over the floor, and his bed was observed to be two toddler sized mattresses on top of the clothing and garbage. The family was offered counseling and funeral services in relation to the death of the SC which were declined. The parents did agree to voluntary prevention services, stemming from the condition of the home and housing instability. The SM and the SF agreed not to co-sleep with the SS and to ensure he had a safe sleep environment available to him. The SS was assessed as safe in the care of the SM and SF and the maternal grandparents throughout the investigation.

SCDSS spoke with LE and the Coroner. The preliminary cause of death was identified as positional asphyxiation, and there were no signs of abuse or other trauma present in the SC.

The pediatrician’s records for the SS and SC were obtained and reviewed by SCDSS. There were no concerns or previously diagnosed medical conditions identified in the records for either child.

The LE and EMS first responders were interviewed by SCDSS. The first responders all provided similar accounts of their knowledge of the fatal incident and condition of the home at the time of their arrival.

The allegation of DOA/Fatality against the SF regarding the SC was substantiated. SCDSS found the SF's actions directly contributed to the death of the SC as confirmed by the preliminary autopsy results. The allegations of IG and IF/C/S against the SM and the SF regarding the SC and SS were substantiated due to the condition of the home at the time of the fatal incident.

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: Saratoga 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
061708 - Deceased Child, Female, 1 Mons	061710 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
061708 - Deceased Child, Female, 1 Mons	061709 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
061708 - Deceased Child, Female, 1 Mons	061710 - Father, Male, 26 Year(s)	DOA / Fatality	Substantiated
061708 - Deceased Child, Female, 1 Mons	061710 - Father, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061708 - Deceased Child, Female, 1 Mons	061709 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061711 - Sibling, Male, 2 Year(s)	061709 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
061711 - Sibling, Male, 2 Year(s)	061710 - Father, Male, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061711 - Sibling, Male, 2 Year(s)	061710 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
061711 - Sibling, Male, 2 Year(s)	061709 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	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?	☒	☐	☐	☐

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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 SM and SF received assistance with housing, though other services were declined during the investigation on behalf of the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM and SF received assistance with housing, though other services were declined during the investigation. The SM was utilizing her own mental health counseling. The SM and SF accepted voluntary preventive services and a long-term case was opened.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? Yes
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
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

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)
05/19/2019	Other Child - Half-sibling, Female, 1 Years	Father, Male, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Other Child - Half-sibling, Female, 1 Years	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Half-sibling, Female, 1 Years	Other Adult - BM to OC, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Half-sibling, Female, 1 Years	Other Adult - BM to OC, Female, 20 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged the home was in deplorable condition with garbage and an insect infestation throughout the home.

Report Determination: Unfounded | **Date of Determination:** 07/13/2019

Basis for Determination:
Rensselaer County Department of Social Services (RCDSS) conducted multiple unannounced home visits throughout the investigation and observed no health or safety hazards to the then 1-year-old half-sibling. Information obtained from collateral sources expressed no concerns for the half-sibling in the care of the SF or the biological mother.

OCFS Review Results:
RCDSS conducted an investigation that met regulatory requirements and made a determination of the allegations in congruence with the evidence gathered.

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

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

The SF had history as an alleged perpetrator dating back to 2013. The SF has had three biological children removed from his care, two of which are placed with their maternal grandmother, and the third placed with the paternal grandmother. The SF had no contact with the children placed with their maternal grandmother and had not since 2016. The SF saw his child placed with the paternal grandmother on a sporadic basis, and his safety was assessed by SCDSS during the recent investigation, although he had no role. The SF had both substantiated and unsubstantiated history for substance misuse and unstable housing. The children were removed from his care in both investigations due to the investigating jurisdictions inability to locate the SF.

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