Child Fatality Report

Report Identification Number: AL-24-023

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

Issue Date: Feb 10, 2025

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
Age: 2 month(s)
Jurisdiction: Albany
Gender: Female
Date of Death: 08/18/2024
Initial Date OCFS Notified: 08/18/2024

Presenting Information

The SCR report stated on the night of 8/17/24 or early morning of 8/18/24, the mother fed the subject child while in bed. At approximately 8:30 AM, the subject child was still sleeping when the mother checked on her. At approximately 11:30 AM, the mother found the subject child unresponsive with blood on the bed. It was unknown if the mother performed cardiopulmonary resuscitation on the subject child, but she did contact individuals with medical knowledge to help her. It was unknown who contacted 911. Emergency medical services responded to the home. Cardiopulmonary resuscitation was performed for at least 45 minutes between the individuals the mother contacted and emergency medical services. The subject child was taken to the hospital and pronounced deceased at 12:27 PM. The subject child was an otherwise healthy child, and the mother had no explanation for her death.

Executive Summary

This fatality report concerns the death of the 2-month-old female subject child that occurred on 8/18/24. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child, as well as Inadequate Guardianship and Inadequate Food/ Clothing/ Shelter against the mother and father regarding the siblings. At the time of her death, the subject child resided with her mother, father, an unrelated household member, and the five surviving siblings, ages 6, 6, 5, 3, and 1.

Albany County Department of Children, Youth, and Families (ACDCYF) completed casework and collateral contacts and learned that on 8/18/24, the mother woke up around 8:30 AM and the subject child was asleep next to her in the parents' bed. The mother left the subject child on the parents' bed and went downstairs to cook breakfast. The mother checked on the subject child at 9:30 AM and noted she was still asleep. The mother checked on the subject child again just after 11:00 AM and found her unresponsive. The mother called two family friends, who were nurses and had just exited the home, and informed them of the subject child's condition. The mother's friends went back into the home and one of them began cardiopulmonary resuscitation while the mother called 911. Emergency medical services responded to the home and continued life-saving measures. The subject child was transported to the hospital where she was pronounced deceased.

An autopsy was conducted, and the final cause of death was listed as accidental asphyxiation from co-sleeping. There was no trauma noted on the subject child. Law enforcement found no criminality related to the subject child's death and no charges were filed.

Bereavement services were offered following the fatality. A preventive referral was completed, however, ACDCYF determined there were no ongoing safety concerns and a family services stage was not opened. During the investigation, it was determined the surviving siblings were being chain-locked in their bedrooms due to the 6-year-old twin siblings previously getting out of the home. ACDCYF ensured the locks were removed from the doors and installed door alarms. The locks remained off the doors for the duration of the investigation and the siblings were deemed safe in the care of the mother and father.

The allegations of DOA/Fatality and Inadequate Guardianship were inaccurately determined. The record reflected a fair preponderance of evidence to support the allegations. The subject child's death was the result of maltreatment, as she was placed in an unsafe sleeping environment resulting in her death. The allegations of Inadequate Guardianship against the

father regarding the subject child should have been added, as the father was aware the subject child was sleeping in an unsafe sleep environment. The mother and father regularly practiced unsafe sleep with the subject child by bedsharing with aggravating factors including pillows and blankets. The allegations of Inadequate Guardianship and Inadequate Food/ Clothing/ Shelter against the mother and father regarding the siblings were appropriately substantiated, as the parents were regularly locking the children in their bedrooms. The case was indicated and closed on 10/29/24.

PIP Requirement

This review resulted in a citation related to casework practice. In response, ACDCYF will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the ACDCYF has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, ACDCYF will review the plan(s) and revise as needed.

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?** No

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?** No

Explain:

ACDCYF inaccurately determined the allegations of DOA/Fatality and IG against the SM regarding the death of the SC, and no allegation of IG was added against the SF regarding the SC despite that he was aware the SC was in an unsafe sleeping environment.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was not commensurate with case circumstances. ACDCYF did not appropriately determine the allegations of DOA or IG related to the SC's death. The record showed a fair preponderance of evidence to support the allegations; however, they were unsubstantiated.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegations of DOA and IG regarding the SC were inaccurately determined. The autopsy listed the cause of death as accidental asphyxiation from co-sleeping. IG should have been added for the SF, as he was aware of the unsafe sleep environment.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACDCYF will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Albany Regional Office if further guidance is needed.

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect contact or attempted contact with the source of the initial SCR report, or emergency room/hospital staff.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACDCYF will contact, or make diligent efforts to contact, the source of all SCR reports so as to verify the adequacy of the report and possibly glean additional information. ACDCYF will document the contact or attempts at contact.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/18/2024 **Time of Death:** 12:27 PM

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

County where fatality incident occurred: Albany
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 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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	33 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)

LDSS Response

Upon receipt of the SCR report, ACDCYF collaborated their investigation with LE, conducted a CPS history review, interviewed the parents and other adults within the home, assessed the safety of the SSs, and implemented appropriate intervention to mitigate safety factors when it was determined the SSs were being locked in their rooms.

ACDCYF interviewed the SM and SF and learned that on 8/17/24, the SM's two friends visited the home for the night. The SM put the SSs to sleep around 8:00 PM. The SM, SC, SF, and the mother's two friends spent time together until 11:00 PM when the SM brought the SC upstairs to the parents' bedroom. The SM put the SC to sleep in the parent's bed, in the middle of the bed between the SM and SF. The SM reported that she fell asleep around 2:00 AM. The SF woke up and left the house around 4:00 AM, as he had to travel for work. The SM awoke around 8:30 AM and noted the SC was asleep next to her at that time. The SM touched the SC's cheek and reported the SC wiggled her nose. The SM went downstairs to cook breakfast and spend time with the two friends. The SM went back upstairs at 8:40 AM and 9:30 AM and stated the SC was still asleep. The SM stated the SC was sleeping on her stomach and "a little to the side." The SM's friends left the home around 11:00 AM and the SM went upstairs to check on the SC. At this time, the SM stated she rubbed the SC's cheek, shook her a little, and grabbed her leg, but the SC did not respond. The SM noted the SC was "cool" and purple. The SM called the two friends, one of which was a nurse, to inform them of the SC's condition. The friends had been in the driveway of the home and returned inside. One of the friends began CPR while the SM called 911. EMS responded and transported the SC to the hospital where she was pronounced deceased. The SM's two friends were interviewed and corroborated the SM's version of events.

The SM denied any medical concerns for the SC, though the SM did report the child had vomited on the evening of 8/16/24. Pediatrician records showed the SC was last seen for a well-child visit on 7/31/24. The SC had a rash, but no

other concerns were noted.

When LE responded to the fatal incident, LE officers found the SSs locked in their bedrooms. This concern was addressed with the parents and rectified immediately. The external locks were removed from the SS's doors, and door alarms were installed. The SSs were deemed safe in the care of the parents. Collaterals had no concerns for the parent's ability to care for the SSs.

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: Albany County referred this fatality to their OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069887 - Deceased Child, Female, 2 Month(s)	069888 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
069887 - Deceased Child, Female, 2 Month(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
069890 - Sibling, Male, 6 Year(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069890 - Sibling, Male, 6 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
069890 - Sibling, Male, 6 Year(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
069890 - Sibling, Male, 6 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069891 - Sibling, Male, 6 Year(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069891 - Sibling, Male, 6 Year(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
069891 - Sibling, Male, 6 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
069891 - Sibling, Male, 6 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

069892 - Sibling, Female, 5 Month(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069892 - Sibling, Female, 5 Month(s)	069889 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
069892 - Sibling, Female, 5 Month(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
069892 - Sibling, Female, 5 Month(s)	069889 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069893 - Sibling, Female, 3 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069893 - Sibling, Female, 3 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
069893 - Sibling, Female, 3 Year(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
069893 - Sibling, Female, 3 Year(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069894 - Sibling, Male, 1 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
069894 - Sibling, Male, 1 Year(s)	069888 - Mother, Female, 31 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069894 - Sibling, Male, 1 Year(s)	069889 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069894 - Sibling, Male, 1 Year(s)	069888 - Mother, Female, 31 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
School	☐	☒	☐	☐
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:

The record did not reflect contact with the source of the initial report, emergency room personnel, or the SS's school. ACDCYF attempted contact with EMS and the SM's doctor; however, were unable to make contact.

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	☒	☐	☐	☐

Explain:
The Risk Assessment Profile was completed inaccurately and did not reflect that the subject child died as a result of maltreatment, which would have resulted in an elevated risk rating.

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?	☐	☒	☐	☐

Explain as necessary:
No children needed to be removed.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
A preventive referral was completed on behalf of the family; however, it was not accepted due to there being no ongoing safety factors.

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
Services were offered on behalf of the SSs.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
Bereavement services were offered to the SM and SF.

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 one unfounded case from out of state regarding the 6yo twin siblings; however, it was unclear based on the records provided by the outside agency who the subject of the report was or what the allegations were regarding. It was noted there were no safety concerns.

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.

Additional Local District Comments

Albany County disagrees with the finding of appropriateness of allegation determination.

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