Child Fatality Report

Report Identification Number: NY-23-005

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

Issue Date: Jun 12, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 01/17/2023
Initial Date OCFS Notified: 01/17/2023

Presenting Information

An SCR report alleged that on 1/17/23, the 1-month-old female subject child was in the care of her mother. The mother noticed that the child was unconscious and was not breathing. The mother called 911 at 8:50 AM and then ran outside of the residence with the child, as there were law enforcement officers outside due to an unrelated incident. The mother and child were transported to a hospital by law enforcement, where the child was pronounced deceased. The child was otherwise healthy and the mother did not have an explanation for her death.

Executive Summary

This fatality report is regarding the death of a 1-month-old female child that occurred on 1/17/23. A report was made to the SCR the same day and alleged DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child. The child resided with her mother, father, and three siblings, ages 4, 6, and 7-years-old. The siblings were assessed to be safe in the care of the mother.

The New York City Administration for Children's Services (ACS) coordinated investigation efforts with law enforcement. It was learned on the evening of 1/16/23, the child was home with the mother and siblings. The grandmother was watching the children earlier in the day while the mother ran errands. The mother returned at 5:00 PM and the grandmother left between 10:00 and 11:00 PM. The siblings fell asleep an hour later and the mother and child stayed up watching television until approximately 1:00 AM. The mother placed the child to sleep in a bassinet. A few minutes later the child began to cry so the mother picked her up and took the child to her bedroom. The mother sat upright against pillows on her bed while cradling the child. On 1/17/23 at 8:00 AM, the mother woke up in the same position and the child was stiff and not breathing. The mother called 911 and then ran the child outside to law enforcement officers who were present due to an unrelated incident in the neighborhood. The child and mother were transported to the hospital where the child was pronounced deceased.

An autopsy was performed and the final results were not yet available at the time the CPS investigation was closed. ACS spoke with the medical examiner's office, who reported the mother fell asleep with the child in her arms, and when she woke the child's face was turned into the mother and the child was not breathing. Law Enforcement determined there was no criminality regarding the death. They reported that the death appeared to be due to a rollover while co-sleeping with the mother. The criminal investigation was pending receipt of the final autopsy report.

ACS provided the family with information on bereavement, mental health counseling, and funeral assistance. ACS found there was not a fair preponderance of evidence to substantiate the allegations against the mother. ACS supported their determination based on the mother stating she fell asleep with the child in her arms and law enforcement not finding any criminality related to the death. ACS opened a preventive services case for the family to provide referrals for community-based services. The investigation was unfounded and closed on 3/18/23.

OCFS' review of the fatality investigation showed that the child had an uncomplicated birth and had no medical conditions. The child was healthy and was not on any medications. The siblings provided that the mother regularly co-slept with the child on her twin-size air mattress. The mother reported to the medical examiner that the child's face was turned into her sweater and she was not breathing the morning of the death. Law enforcement reported the death was likely due to a rollover, as the mother was co-sleeping with the child. Based on the information provided by the mother, siblings, medical examiner, and law enforcement, there was a fair preponderance of evidence to substantiate Inadequate

Guardianship and DOA/Fatality against the mother; however, the investigation was unfounded.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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:
The 24-hour safety assessment tool was completed late on 1/20/23 and was inaccurate, as it documented a safety decision 3, despite no safety concerns noted in the record other than unsafe sleep which did not apply to the 4, 6, and 7-year-old siblings. During ACS' internal review, ACS identified this inaccuracy and documented a correct safety modification.

Was the decision to close the case appropriate? N/A

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:
Although all other casework activity was commensurate with case circumstances, the determination was not supported by the information gathered during the investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination

Child Fatality Report

Summary:	Though the criteria regarding a fair preponderance of evidence was met with the information documented in the case record, ACS did not appropriately determine the investigation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/17/2023 **Time of Death:** Unknown

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 08:50 AM
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Other Household 1	Father	No Role	Male	32 Year(s)

LDSS Response

Upon receipt of the SCR report on 1/17/23, ACS immediately initiated their investigation, coordinated efforts with law enforcement and the Child Advocacy Center, spoke with the Medical Examiner, completed interviews with the family, and

assessed the safety of the siblings.

ACS interviewed the mother, who reported the day prior to the death, the mother ran errands and was in and out of the home periodically. The maternal grandmother stayed with the children, and the mother reported they appeared well when she saw them. The mother returned home for the day around 5:00 PM. The grandmother left the home between 10:00 and 11:00 PM. The siblings fell asleep at 12:00 AM and the mother and child stayed up until 1:00 AM. The mother watched television and the child was in a bouncer seat. The mother laid the child in her bassinet, but after a few minutes, the child began to cry and the mother picked her up. The mother reported the child liked to be held and cuddled when falling asleep. The mother took the child to her bedroom and sat upright against pillows on her twin-size air mattress. The 6-year-old sibling was already asleep on the mother's air mattress. The mother held the child in her arms and soon after they both fell asleep. On 1/17/23 at 8:00 AM, the mother woke up and she and the child were in the same position. The sibling was asleep and the child was stiff and not breathing. The mother called 911 and began CPR. There were police officers outside of the home due to an unrelated incident in the neighborhood, so the mother ran the child outside to ask for help. The child and mother were transported to the hospital where the child was pronounced deceased.

The mother reported the child had an uncomplicated birth and had no medical issues. The child recently switched from breast to bottle feeding and was fed every two hours. The child was not on any medications. The family recently moved to the home and the mother was in the process of obtaining furniture. The maternal grandmother brought a bassinet for the child to sleep in on 1/16/23, but the mother reported regularly co-sleeping with the child. The parents reported they were not educated on safe sleep when the child was born; however, received safe sleep information following the birth of a sibling.

The 7-year-old sibling was interviewed at the Child Advocacy Center and the other two siblings were interviewed at the home. The siblings reported the child slept with the mother. There were no safety concerns disclosed during their interviews. The father of the child and 4-year-old sibling was interviewed and reported he learned of the death from the mother, who called him hysterical the morning of the incident. The father was not present when the death occurred, and only had information from the mother, who had told him she fell asleep while holding the child and woke up to the child not breathing. The father had no concerns for the mother's care of the children. ACS spoke to the grandmother and an aunt, who reported they had no concerns for the children. ACS documented efforts to locate and speak to the father of the 6 and 7-year-old siblings; however, they were unsuccessful.

ACS conducted a child safety conference in which the mother and father participated. It was reported the parents were cooperative with ACS and the recommended services for the siblings, including bereavement counseling and play therapy. The mother enrolled the children in school in their new district and there were no concerns reported by their previous district. There was no family court intervention recommended. The family was provided with information on community-based services. There was no need for further child welfare involvement and the investigation and services case was closed.

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? No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063705 - Deceased Child, Female, 1 Mons	063706 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
063705 - Deceased Child, Female, 1 Mons	063706 - Mother, Female, 26 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:

ACS made efforts to speak to the physician who treated the child upon her arrival to the emergency department; however, they 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents were accepting of referrals for services but it was unknown at case closure if they engaged in the services offered.

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? Yes
Explain:
ACS provided the family with information on community-based services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided the parents with information on community-based services, including bereavement and burial assistance. In addition, ACS ordered beds for the family.

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 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