Child Fatality Report

Report Identification Number: NY-23-029

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

Issue Date: Jul 18, 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		

Case Information

Report Type: Child Deceased **Jurisdiction:** Kings **Date of Death:** 03/06/2023
Age: 4 month(s) **Gender:** Female **Initial Date OCFS Notified:** 03/07/2023

Presenting Information

On 3/5/23, the 4-month-old subject child was found unresponsive in her crib with plastic over her face and blood coming from her nose. Upon finding the child, the mother picked her up and ran outside to the father, who had just arrived home. The father called emergency medical services. Emergency medical services arrived at the home, took over life-saving efforts, and transported the child to the hospital. While at the hospital, the child went into cardiac arrest and organ failure. The child died on 3/6/23.

Executive Summary

This fatality report concerns the death of the 4-month-old female subject child. The Administration for Children's Services (ACS) received an SCR report regarding the child's death on 3/7/23. The fatality occurred during an open CPS investigation, which was initiated on 3/5/23, precipitated by the incident that led to the fatality. At the time of the child's death, she resided with her father, mother, and three siblings (ages 5, 4, and 2).

On 3/5/23, shortly after 12:30PM, the mother was alerted by the housekeeper that something was wrong with the subject child. The mother, who was in the kitchen at the time, immediately checked on the subject child, who had been recently been placed down for a nap in her crib. The mother found the child in her crib, with a plastic bag obscuring her mouth and nose. There was blood observed coming from the child's nose. The mother picked up the child and brought her outside to the father, who had just arrived home. The father began CPR and emergency medical services was called. The child was transported to the hospital in cardiac arrest. Once stabilized in the emergency department, the child was transferred to the neonatal intensive care unit for further intervention. The child had a poor prognosis at that time and on 3/6/23, she became unresponsive and was pronounced dead.

The medical examiner was notified of the death. Due to religious practices, the child was buried the day following her death, and a religious exemption was requested which limited the scope of the autopsy. An external exam revealed no indication of inflicted injury, marks, or bruises and a viral panel showed no evidence of respiratory viruses. ACS confirmed the medical examiner was aware a plastic bag was found covering the child's mouth and nose. Ultimately, the cause and manner of death were undetermined; however, hospital records indicated the child was "likely a victim of accidental asphyxiation in the setting of an unsafe sleeping environment." Law enforcement investigated and closed their case without charges being brought against either parent.

ACS made several home visits and interviewed the parents, housekeeper, and additional family members who had knowledge of the parents' caretaking abilities. All siblings were assessed to be safe and remained in the parents' care.

ACS substantiated the allegations against the mother regarding the subject child. ACS determined there was a fair preponderance of evidence to suggest the mother failed to meet a minimum degree of care of the child. The mother failed to regularly exercise safe sleep in that it was her normal practice to leave the diapers and diaper bags in the child's crib. This practice placed the child in imminent risk of harm, and ultimately resulted in the child's death.

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 siblings were assessed to be safe. The family was engaged in community-based services and declined further ACS assistance. Safe sleep was addressed and as there were no longer CPS safety concerns, the case was closed.

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: 03/06/2023 **Time of Death:** 06:28 PM

Date of fatal incident, if different than date of death:	03/05/2023
Time of fatal incident, if different than time of death:	Unknown
County where fatality incident occurred:	Kings
Was 911 or local emergency number called?	Yes
Time of Call:	12:44 PM
Did EMS respond to the scene?	Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs?	No

Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Father	No Role	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 3/5/23, ACS received a report that alleged the subject child was hospitalized after being found in her crib unresponsive. A subsequent SCR report was received 3/7/23, and alleged the subject child died because of their injuries. ACS initiated their investigation upon receipt of the initial SCR report and coordinated their efforts with law enforcement. The sources of the reports were contacted, the DA was notified of the death, and a history check revealed the family had no child welfare history. ACS assessed the safety of the surviving siblings upon receipt of the initial report.

ACS interviewed the parents regarding the events leading up to the child’s death. On 3/5/23, the father left the home around 8:30AM to attend religious services, run errands, and did not return until around 12:40PM. The mother was home with the child and siblings. The morning consisted of the child’s normal feeding and napping routine. The mother reported when she laid the child down for her nap, she placed the child on her back and in her crib which was in the parents' bedroom. At 12:30PM, the housekeeper arrived for her usual shift and the mother instructed her to change the bedding in the parents’ bedroom, where the child was sleeping. The mother was next alerted to something being wrong with the child by the housekeeper. There was a language barrier between the housekeeper and mother; however, when she heard the word “baby” the mother immediately went to check on the child. The mother found the child with a plastic bag over her mouth and nose. The mother described the bag as a plastic bag used for dirty diapers, and it was in the crib because the mother typically changed the child in her crib and found it convenient to leave the diaper bag and diapers in the crib. The parents offered conflicting information on the child’s ability to roll over. The housekeeper confirmed she arrived at 12:30PM and changed the bedsheets as instructed, which took about 10 minutes. She noticed the child was not breathing and appeared pale, so she notified the mother. The housekeeper noticed blood, and saw a plastic bag in the child’s hand, and the child’s hand was covering her face. The housekeeper confirmed other items like loose diapers were in the crib as well. The mother grabbed the child and ran outside to the father, who was arriving home at that time. The mother handed the child to the father, who began CPR. The record was inconsistent on which parent called for emergency medical services. The father continued CPR until emergency medical services arrived. Emergency medical services took over life-saving efforts and transported the child to the hospital, where she was pronounced dead the following day.

The child arrived at the hospital with no heart rate or respiratory rate. After continuous resuscitative efforts, a return of spontaneous circulation was detected, and the child was intubated. The child's prognosis was poor, and she was transferred to the pediatric intensive care unit. Due to cardiac and respiratory failure, the child had liver and lung damage and her major organs were failing. On 3/6/23, the child became unresponsive and was pronounced dead at 6:28PM. Medical staff expressed they felt unsafe sleep contributed to the respiratory and cardiac arrest. Law enforcement expressed similar sentiments.

The siblings were interviewed; however, had limited input. The 5yo sibling reported the subject child choked on a plastic bag, and she knew this because she heard it from her parents. ACS reached out to additional relatives who had no further information regarding the fatal event, but who expressed no concerns with the parents' overall care of the children.

ACS was sensitive to the family's religious and cultural practices and made efforts to offer culturally congruent services, although the family ultimately declined further preventive services from ACS.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Unknown

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: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063808 - Deceased Child, Female, 4 Mons	063809 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated
063808 - Deceased Child, Female, 4 Mons	063809 - Mother, Female, 26 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?	☒	☐	☐	☐
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	☒	☐	☐	☐
Explain:				

The family was provided with age-appropriate resources to engage the younger siblings in grief services. ACS collaborated with community providers already involved with the family to ensure appropriate services were offered.

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	☐	☒	☐	☐	☐	☐	☐

Other, specify: Preventive Services
Additional information, if necessary: The family engaged with a community-based organization for crisis services following the death of the subject child. Faith leaders in the community were closely involved with the family and offered to provide religiously and culturally sensitive referrals to agencies that provided parenting skills, early intervention, and additional counseling services as needed.

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:
The family was working with community-based providers who offered the children crisis services and educated the parents on how to talk with the young siblings about the subject child's death. The community-based agency provided supportive intervention and guidance, and had the ability to refer the family for additional services if the need arose.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The father had engaged in counseling services prior to the close of the investigation. The record reflected the mother had participated in an intake; however, was not yet engaged in services. The family was also working with their religious leaders who were aware of the passing of the child and could refer the family for services within the community.

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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used prescription drugs
- ☐ Used marijuana
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ With fetal alcohol effects or syndrome
- ☐ Exhibiting withdrawal symptoms
- ☒ 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