Child Fatality Report

Report Identification Number: NY-23-052

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

Issue Date: Aug 11, 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
Age: 4 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 05/25/2023
Initial Date OCFS Notified: 05/25/2023

Presenting Information

Two SCR reports were received regarding the subject child's death, both alleging that the mother fell asleep after placing the child in bed with her. On 5/25/23, at 7:30AM, the mother woke to find the child unresponsive. EMS was contacted and CPR was attempted. EMS transported the child to the hospital, where she was pronounced dead at 8:04AM. It was alleged the unsafe sleep environment contributed to the child's death. Additionally, one report alleged the mother and father delayed seeking medical care for an hour. The child was otherwise healthy.

Executive Summary

This report concerns the death of the 4-month-old subject child that occurred on 5/25/23. The Administration for Children's Services (ACS) received two SCR reports regarding the death. At the time of her death, the child resided in a shelter with her mother, father, and two siblings, ages 7 and 1. The family arrived in the United States from their country of origin in December 2022, and to New York City in January 2023, where they entered the city's shelter system.

On the evening of 5/24/23, the subject child was fussy and did not go to sleep until 1:00AM the morning of 5/25/23. The child was placed to sleep on her back, in an adult-sized bed with the mother. The mother and child had co-slept since the child was two months old, although a Pack 'N Play had been provided to the family upon arrival to the shelter. When the mother woke at 7:30AM she found the child on her stomach, unresponsive, and her face was purple in color. The mother screamed, woke the father, and the parents brought the child to the medical office in the shelter for assistance. Medical staff administered CPR and called 911. EMS responded, took over resuscitative efforts, and transported the child to the hospital where she was pronounced dead at 8:04AM.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed. ACS spoke with the medical examiner and inquired whether the child's death could have been a result of the sleeping environment; however, the record was unclear regarding the response. A supervisory note reflected a directive to clarify the information, yet the casework did not reflect follow-up was completed; therefore, it remained unknown if the sleeping environment played a role in the death. The medical examiner was not asked about overall impressions of the child's physical appearance. Additionally, a directive to follow up with the medical legal investigator was not reflected in the record. Releases were sent to the hospital; however, the record did not reflect any further inquiry. Law enforcement's investigation into the death remained pending the final autopsy report; however, no criminality was suspected.

ACS made several home visits and interviewed the father. The mother was too distraught to engage in an interview immediately following the fatality. The parents did not allow ACS to interview the 7-year-old sibling; however, information was gathered from law enforcement's interview. The family retained an attorney, which created challenges for ACS being able to conduct ongoing interviews. The siblings were assessed to be safe with the parents.

ACS unsubstantiated all allegations against the parents; however, the record reflected multiple reports of the mother routinely bed sharing with the child over a period of at least two months, which supported a finding of imminent danger to the child. Additionally, the physical condition of the shared sleeping area was unsafe in that pillows were present as the child was reportedly found face down, on or under a pillow. ACS concluded based on reports from shelter staff that because the mother attended prenatal appointments, the child was physically well and attended pediatric appointments, the parents had knowledge of safe sleep guidance, and the shelter provided two cribs to the family that there was no fair

preponderance of evidence to substantiate Inadequate Guardianship and DOA/Fatality. Lack of Medical Care was unsubstantiated as the medical examiner reported the child was seen by a pediatrician and there were no medical concerns. A delay in medical care upon discovering the child unresponsive was not supported by interviews.

The parents accepted bereavement services on behalf of the 7-year-old sibling. The shelter assisted with funeral arrangements.

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?** 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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:

The record reflected the subject child was routinely placed in imminent risk by co-sleeping with aggravating factors present. Additionally, the relationship between how the child was found and the cause of death was not fully explored with relevant collaterals.

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:

A Family Services Stage remained open to ensure delivery of requested services. Casework was not commensurate with case circumstances in that the allegation of IG was incorrectly determined. Additionally, there were missed opportunities to gather information relevant to the cause of death from the ME, hospital, and legal medical investigator prior to closing

the CPS investigation.

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 allegation of IG was unsubstantiated; however, the record reflected multiple reports that the mother routinely co-slept with the child since the age of 2 months in an adult-sized bed with aggravating factors, despite access to two Pack 'N Plays.
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.
Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	The allegation of DOA/Fatality was pre-determined. There were missed opportunities to gather information relevant to the cause of death from the ME, hospital, and legal medical investigator prior to closing the CPS investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/25/2023 **Time of Death:** 08:04 AM

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

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 07:32 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

LDSS Response

ACS initiated their investigation timely, coordinated efforts with law enforcement, contacted the sources of the reports, completed a CPS history check, and informed the DA of the fatality. The safety of the siblings was assessed, and a visit to the shelter was conducted the day of the fatal incident.

ACS interviewed the father regarding the events leading up to the child's death. The father described the 24 hours preceding the death. On 5/24/23, the mother brought the child with her when she took the 7yo sibling to school at 8:20AM. They returned at 9:20AM and the mother, father, and 1yo sibling remained in the shelter until the mother had to pick up the 7yo sibling from school. At 4:00PM the family went to the laundromat, grocery shopping, got dinner, and returned to the shelter at 9:00PM. The child was given a taste of soup, breastfed, and burped. The child did not end up settling to sleep until 1:00AM early the next morning (5/25/23). The child was placed to sleep on her back in bed with the mother. The father reported the mother and child had co-slept since the child was two months old because the child did not sleep well in the Pack 'N Play but slept well in the bed with the mother. The father did not sleep in the same bed that night, though had previously. The father said the mother told him the child woke during the night at 4:00AM, cried, then went back to sleep. The father woke to the mother's screams at 7:30AM. Prior to going to bed that night, the child appeared healthy. The father expressed knowledge of safe sleep recommendations and the family had access to two Pack 'N Plays, though neither was utilized for sleep.

ACS was unable to interview the mother; however, learned from law enforcement that the mother reported at 1:00AM she placed the child next to her, on her back, on an adult-sized bed. She placed the child next to her because the child would not stop crying in the Pack 'N Play. When the mother woke at 7:30AM, she went to the bathroom to start a shower for the 7yo sibling. When she returned, she saw the child on her stomach. Her face was purple, and she was unresponsive. The mother immediately sought medical assistance through the shelter's medical office. CPR was in progress by shelter medical staff upon EMS arrival. The child was in cardiac arrest and her response to medical interventions remained unchanged. The child was taken by ambulance where ongoing resuscitation efforts were continued uninterrupted enroute to the hospital.

The parents did not allow ACS to interview the sibling about the fatal event; however, law enforcement had prior to ACS's involvement. The sibling reported the subject child always slept in the mother's bed. The 7yo and 1yo siblings shared a bed as well. That morning, when the sibling woke up for school, while she was in her room, she saw the mother go to the bathroom. When the mother returned to her bedroom, the mother was panicked. The 7yo sibling said she then saw the mother lift a pillow that was in a crack between the bed and the wall and saw the mother pick up the child from that same space in between the bed and the wall.

Shelter staff were spoken with, and it was confirmed the parents had been provided safe sleep guidance and sleeping arrangements. Staff denied any concerns with the family prior to this incident.

ACS was limited in the information they could gather from the family due to the family obtaining legal representation. Through their own legal team, ACS attempted to schedule a meeting between all parties; however, a meeting did not occur prior to the investigation closing. All allegations were unsubstantiated, the report was unfounded and closed on 7/17/23.

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: 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
064484 - Deceased Child, Female, 4 Mons	064487 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
064484 - Deceased Child, Female, 4 Mons	064487 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
064484 - Deceased Child, Female, 4 Mons	064487 - Mother, Female, 24 Year(s)	Lack of Medical Care	Unsubstantiated
064484 - Deceased Child, Female, 4 Mons	064488 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
064484 - Deceased Child, Female, 4 Mons	064488 - Father, Male, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
064484 - Deceased Child, Female, 4 Mons	064488 - Father, Male, 24 Year(s)	Lack of Medical Care	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?	☐	☒	☐	☐

Emergency Room Personnel	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 mother declined to be interviewed and did not allow ACS to interview the 7yo SS; however, information was gathered from LE's interview. There was no documented follow-up with the hospital regarding a release of information sent on 6/1/23.

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 father reported frequent marijuana use; however, this was not explored further, and it was unknown if his use impacted his caretaking capacity.				

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							

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 7yo sibling was referred to trauma-focused therapy. At the time the CPS investigation closed, an intake appointment had been scheduled. A daycare voucher was offered and accepted on behalf of the 1yo sibling. Efforts were being made to secure the voucher at the end of the investigation. A Family Services Stage was opened to ensure both outstanding tasks were completed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Burial assistance was provided by the shelter. The parents were provided bereavement resource by both the shelter and ACS, though had not engaged in services at the time the CPS investigation closed. Preventive services were offered and declined. The family reported the shelter had been supportive and helpful following the death. The record reflected substance use resources were provided to the father, although no discussion with the father regarding his use was documented.

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.

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