



Report Identification Number: NY-23-092

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

Issue Date: Mar 26, 2024

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: Kings
Gender: Female

Date of Death: 10/08/2023
Initial Date OCFS Notified: 10/08/2023

Presenting Information

The New York City Administration for Children’s Services (ACS) received an SCR report on 10/8/2023 which alleged the mother (SM) fell asleep with the 3-month-old child (SC) on an air mattress. The child was found unresponsive on the air mattress by the mother’s cousin (OA). A call was made to 911, CPR was initiated by the mother and her cousin, and the child was transported to the hospital by ambulance where she was pronounced dead. It was suspected the unsafe sleep practices contributed to the child’s death.

Executive Summary

This report concerns the death of a 3-month-old child which occurred while in the care of her mother. The mother was visiting her cousin’s home from Connecticut for a family party. The cousin was outside the home and had returned to find the mother and child co-sleeping on an air mattress. The cousin noticed the child had vomited and was unresponsive. The cousin woke the mother, called 911, and initiated CPR until first responders arrived. The child was transported to the hospital by ambulance where she was pronounced dead.

The mother and the cousin were interviewed by ACS. The mother and cousin stated they had been at a family party and consumed alcohol, though neither were intoxicated. The mother denied co-sleeping with the child and stated she was in the bathroom when the cousin alerted her something was wrong with the child. The cousin was interviewed on two separate occasions and confirmed she was outside at the time of the fatal incident and before she had left the mother and child were awake. Upon her return, she saw the mother and child asleep together on the air mattress. The cousin stated she saw vomit around the child, and she was unresponsive when she went to tend to her.

The medical examiner was interviewed and stated the unsafe sleep environment may have contributed to the child’s death. Further testing was pending, and the final autopsy was not available at the time the investigation was closed.

The allegations of DOA/Fatality and Inadequate Guardianship against the mother were substantiated. Services in relation to the death were offered, though it was unclear from the case record if the mother was participating in them at the time the investigation was closed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
 - **Safety assessment due at the time of determination?**

Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the**

Yes, sufficient information was gathered to determine all



investigation?

allegations.

- Was the determination made by the district to unfound or indicate appropriate?

Yes

Explain:

Sufficient information was gathered to make a determination of the allegations and the decision to close the case was made commensurate with the case circumstances.

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:

There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

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: 10/08/2023

Time of Death: 02:24 AM

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

01:46 AM

County where fatality incident occurred:

Kings

Was 911 or local emergency number called?

Yes

Time of Call:

01:46 AM

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	Mother	Alleged Perpetrator	Female	36 Year(s)

LDSS Response

ACS received the SCR report and coordinated their response with LE. LE informed ACS the SM had been interviewed and denied co-sleeping with the SC. The SM, SC, and OA were at a family party before returning to the OA's home. The SM smelled strongly of alcohol during the interview though LE stated she did not seem intoxicated.

ACS interviewed the SM and OA in the MGM's home. The SM stated she was visiting the OA from Connecticut for a family party at the MGM's home. The SM stated she and the OA consumed alcohol before returning to the OA's home with the SC. The SM stated she was not intoxicated and had approximately three drinks. The SM stated she and the OA were playing with the SC, the SC spit up on her, she then took a shower, and the OA was watching the SC on the OA's bed. The SM stated the OA yelled for her while she was in the bathroom and the SM entered the room and the SC was unresponsive.

The OA stated in two separate interviews she and the SM returned to her home from the family party. The OA and SM were both playing with the SC, the SC spit up on the SM, and the SM went to shower. The OA stated the SM returned from her shower, and they continued to tend to the SC together. The OA stated she then went outside to smoke and was outside an undetermined amount of time. Upon returning inside, the SM and SC were asleep together on the air mattress. The OA stated she saw the SC was face-down, had vomited, and was unresponsive when she tried to wake her. The OA awoke the mother, called 911, and initiated CPR until LE and EMS arrived.

ACS contacted Connecticut and obtained CPS history for the SM. A request was made by ACS for Connecticut to assess the safety of surviving half-siblings in the care of their respective fathers. It was unclear from the record if in-person assessments were made, though ACS made diligent efforts to contact the fathers and discuss the case with them. Neither had direct knowledge of the fatal incident and stated their children have little to no contact with the SM.

ACS interviewed the ME. The ME and ME investigator identified there was no trauma or signs of abuse present in the SC. The ME stated the SM had reportedly used alcohol the night of the fatal incident and the unsafe sleep environment may have contributed to the SC's death. The final autopsy was pending at the time the investigation was closed. LE informed ACS there would be no criminal charges pursued against the SM.

Services in relation to the death of the child were offered and accepted by the SM. The SM was advised by ACS to pursue services through her insurance provider, and it was unknown from the case record if the SM was engaged in services at the time the investigation 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: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066428 - Deceased Child, Female, 2 Month(s)	066429 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated
066428 - Deceased Child, Female, 2 Month(s)	066429 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Legal Activity Related to the Fatality

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



Child Fatality Report

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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine

Explain:

The SM was offered and accepted grief counseling, though was advised by ACS to go through her insurance which was not accepted in NYS. It was unclear from the case record if the SM was participating in services at the time the investigation was closed.

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:**

- | | |
|--|---|
| <input type="checkbox"/> Had medical complications / infections | <input type="checkbox"/> Had heavy alcohol use |
| <input type="checkbox"/> Misused over-the-counter or prescription drugs | <input type="checkbox"/> Smoked tobacco |
| <input type="checkbox"/> Experienced domestic violence | <input type="checkbox"/> Used illicit drugs |
| <input type="checkbox"/> Had a positive toxicology at the time of delivery | <input type="checkbox"/> Used prescription drugs |
| <input type="checkbox"/> Used marijuana | <input checked="" type="checkbox"/> Was not noted in the case record to have any of the issues listed |

Infant was born:

- | | |
|---|---|
| <input type="checkbox"/> With a positive toxicology | <input type="checkbox"/> With fetal alcohol effects or syndrome |
| <input type="checkbox"/> Exhibiting withdrawal symptoms | <input checked="" type="checkbox"/> 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

The SM was named in one court ordered investigation in 2017 which alleged the SM was the victim of domestic violence and the BF to the SS who lived out of state filed for custody of the SS. The BF was awarded custody and the case was closed.

Known CPS History Outside of NYS

There were 14 investigations, 3 of which were tracked for FAR, and all of which were unsubstantiated. Common allegations included the SM's substance misuse, erratic behavior, and inadequate supervision of the surviving half-siblings.

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