Child Fatality Report

Report Identification Number: NY-23-102

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

Issue Date: Apr 09, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 28 day(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 10/23/2023
Initial Date OCFS Notified: 10/23/2023

Presenting Information

An SCR report alleged that on 10/23/23 at 4:00 AM, the mother and father placed the 28-day-old subject child in her bassinet and then went to sleep. At 9:00 AM, the mother woke up and found the child was unresponsive. The mother contacted 911 and began to perform cardiopulmonary resuscitation. Law enforcement and emergency medical services responded to the home and continued life-saving measures. The child was transported to the hospital where she was pronounced deceased at 10:08 AM. The child was otherwise healthy and the parents had no explanation for the child's death.

Executive Summary

This fatality report is regarding the death of a 28-day-old female child that occurred on 10/23/23. An SCR report was made on the same day and included allegations of Inadequate Guardianship and DOA/Fatality against the mother and father. The child resided with her mother, father, and 3-year-old sibling. The sibling was determined to be safe in the care of the parents.

The Administration for Children's Services (ACS) initiated their investigation and gathered information regarding the death from the family and collaterals. On 10/22/23, the family left the home to go to the grocery store. The family returned to the home around 5:00 PM and the mother fed the child. The child spit up following the feeding, which was reported to be normal. The child was placed in a baby swing in the living room with the father. At 10:30 PM, the mother placed the child to sleep on her back in her bassinet. The mother covered the child with a fleece blanket up to her stomach. On 10/23/23 at 12:30 AM, the child woke up and the mother fed her. The child spit up and cried during the feeding. The child fell back to sleep and the mother placed her on her back in the bassinet at 3:30 AM. The mother woke up at 8:00 AM and fell back to sleep until 9:00 AM when she checked on the child. The child was unresponsive and cold to the touch. The father called 911 and the mother performed cardiopulmonary resuscitation per the instruction of 911 dispatch. Emergency medical services responded and transported the child to the hospital where she was pronounced deceased.

An autopsy was completed; however, the final results were pending further studies at the time this report was written. The medical examiner's office completed a re-enactment with the parents at the home. There were no concerns regarding unsafe sleep based on the demonstration by the parents; however, it was stated that there was clothing strewn about in the bedroom near where the child was sleeping and there would be additional testing to see if co-sleeping was a contributing factor for the child’s death and/or if it was due to the child suffocating from items in the crib. There were no signs of trauma during the physical examination. Law enforcement investigated the fatality and suspected no criminality.

ACS unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the parents. The Investigation Conclusion Narrative stated ACS did not find a preponderance of evidence to support that the child's death was caused by abuse or maltreatment by the parents. The allegation of Inadequate Guardianship was inappropriately determined. The record reflected that the child slept with a blanket in her bassinet, creating an unsafe sleep environment for the child, and placing her at risk of harm.

The mother and sibling enrolled in bereavement counseling but the father declined a referral. Due to his marijuana use, ACS requested that the father complete a drug screen and engage in a substance abuse referral; however, he declined to participate. The father reported his marijuana use was not relevant, as the mother was the primary caretaker, and the mother denied drug use. ACS provided the family with the appropriate referrals, and a Preventive Services Case was

opened to assist the family with fatality-related services. The investigation was unfounded and closed on 12/22/23.

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

Explain:
The safety of the sibling was assessed throughout the investigation.

Was the decision to close the case appropriate? Yes

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

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

Explain:
Although all other casework activity was commensurate with case circumstances, the determination of Inadequate Guardianship was not appropriate given the information obtained during ACS' 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 record reflected the SC was placed to sleep with a fleece blanket, creating an unsafe sleep environment for the child, and this information did not appear to be considered when determining the

	allegation of Inadequate Guardianship.
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: 10/23/2023 **Time of Death:** 10:09 AM

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: 09:15 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	28 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

Upon receipt of the SCR report on 10/23/23, ACS coordinated their investigation with LE, sent notification to the ME and DA, interviewed the family, spoke with collaterals, and offered the family fatality-related services.

ACS interviewed the parents regarding the events leading up to the death. The SM reported that on 10/22/23, she and the family left the home to get groceries and returned at 5:00 PM. The SS watched television with the SF in the living room

and the SM fed the SC. The SC spit up some of the milk through her mouth and it was running out of her nose. The SM reported this was normal for the SC and the SC's pediatrician was aware. The SM placed the SC in a baby swing in the living room with the SF. The SM ate dinner and then spent time in her bedroom watching television with the SS. The SS fell asleep at 10:00 PM and the SM placed him on his toddler bed. The SM retrieved the SC from the living room and prepared the SC for bed before placing her on her back in the bassinet. The SM placed a fleece blanket over the SC's stomach. The SM explained the apartment had controlled heat that was not yet turned on so it was cold. The SM went to sleep shortly after and woke up on 10/23/23 at 12:30 AM to feed the SC. The SC was crying and spitting up the milk. The SM burped the SC and cleaned her up. The SC stopped crying and the SM placed her back to sleep in the bassinet at 3:30 AM. At 8:00 AM, the SM woke up and realized it was too late for the SS to go to school, so she went back to sleep. The SM was woken up by the SF at 9:00 AM. When the SM checked on the SC, the SC had blood on her nose and a mucus bubble in her nose. The SC was cold to the touch and the SM retrieved the SC from the bassinet and ran to the living room, informing the SF of the SC's condition. While the SF was outside waiting for EMS, the SM performed CPR. It was not clear from initial interviews what position the SC was found in. When ACS attempted to gather this missed information, the parents no longer wished to discuss the fatality. The SF confirmed the SM's account of events. On 10/23/23, the SF woke up at 9:00 AM and noticed the family had overslept and the SS was late for school. The SF woke up the SM who stated the SS was not going to school. The SF began getting ready for work when he was informed by the SM that the SC was not breathing. The SF called 911 and went outside to wait for EMS per the instruction of the dispatcher.

ACS completed several home visits and there were no concerns noted about the condition of the apartment. The children had appropriate sleeping arrangements and provisions. The SC slept in a bassinet, which had items in it during the visit, but the SM reported they were removed when the SC slept. ACS attempted to engage the SS in an interview. The SS stated he saw the SC with blood on her nose and she was cold, but otherwise, he minimally participated. ACS observed the SS during several face-to-face contacts and determined he was safe. ACS documented diligent efforts to speak to the BF of the SS; however, he did not make himself available for an interview during the investigation. The SM reported he was not involved in the SS's life.

ACS interviewed relatives, including several aunts and both grandmothers. The relatives reported regular contact with the family. Some of the relatives saw the SC the day prior at a birthday party, and there were no concerns at that time. One of the grandmothers expressed concern with the SF's ongoing marijuana use.

ACS gathered information from the pediatrician's office. The SC had been a patient at the office since 9/28/23 and had no medical diagnosis. The SC was last seen on 10/17/23 and the pediatrician did not observe any concerns. The pediatrician was not aware that the SC was having milk run from her nose and was spitting up but stated it was normal for a baby to spit up milk after they were fed. The SS was also in receipt of medical care and there were no concerns for him.

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: NYC does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066331 - Deceased Child, Female, 28 Day(s)	066332 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
066331 - Deceased Child, Female, 28 Day(s)	066332 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
066331 - Deceased Child, Female, 28 Day(s)	066333 - Father, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
066331 - Deceased Child, Female, 28 Day(s)	066333 - Father, Male, 27 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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 documented diligent efforts to speak with the sibling's father during the investigation; however, their efforts were unsuccessful. The record did not reflect EMS was contacted regarding their response to the home.

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 family was offered and accepted bereavement counseling, funeral assistance, assistance obtaining household items, and preventive services. The father was offered a substance abuse evaluation due to his marijuana use; however, declined to participate. The family was offered a daycare voucher and it was unclear if they utilized the service.

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

The mother had an unfounded CPS investigation in 2018 regarding a cousin. The allegations of Excessive Corporal Punishment and Inadequate Guardianship were unsubstantiated.

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