Report Identification Number: SV-23-031

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

Issue Date: Nov 30, 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: Westchester
Date of Death: 06/26/2023
Age: 2 month(s)
Gender: Female
Initial Date OCFS Notified: 06/26/2023

Presenting Information

The initial SCR report received on 6/26/23 stated that on that same day, the mother fell asleep with the subject child in her arms. When the mother woke up, the child was not breathing. The mother called 911. The father was in the home at the time. Medical personnel arrived at the home and attempted life-saving measures. The child was transported to the hospital around 4:06PM where she was pronounced dead. A second report was received that same day and alleged that around 12:00PM, the mother and father slept in the same bed as the subject child. When they woke up at 3:30PM, the child was unresponsive. A third report received 7/7/23 further added that the child and twin sibling were placed on an adult bed for a nap. The mother laid down on the bed with the children and when she woke, the subject child was unresponsive. This report added the twin sibling to the allegations. All three reports said the unsafe sleep environment contributed to the death.

Executive Summary

This report concerns the death of the 2-month-old subject child. Westchester County Department of Social Services (WCDSS) received multiple SCR reports regarding the child's death, which occurred on 6/26/23. At the time of the child's death, she resided with her twin sibling, mother, and father. The family resided in the basement of the paternal grandparents' home, along with the grandparents' 3-year-old and 18-year-old children.

On the evening of 6/25/23, the parents had friends over to celebrate a birthday. Their friends left around 1:00AM the morning of 6/26/23. The parents stayed up watching movies while in bed with the subject child and twin sibling. Around 5-6:00AM, the children were fed, burped, and placed back down on the parents' bed. The father slept on the end of the bed closest to the wall, the subject child was nearest him, the sibling next to the subject child, and the mother on the other side of the sibling. The father woke up sometime between 10:00AM and noon, at which point he checked on the children and they were fine. He tried to wake the subject child to feed her; however, she did not wake up. The father said the mother was asleep; however, the mother stated she believed she was awake and fed the sibling around 11:00AM. The father went back to sleep until about 3:30PM. When he tried at that time to wake the subject child, she was cold to the touch. She was laying face up, with her eyes closed, and the father observed mucus in her nose. When a blanket did not warm her body, the father placed his ear next to her nose but did not hear breathing. He then placed his ear next to her heart but did not hear a heartbeat. He woke the mother and they called 911, as well as the paternal grandfather. The father was instructed on how to perform CPR. The paternal grandmother returned to the home shortly before the arrival of numerous emergency services and performed CPR. Upon arrival, EMS took over life-saving measures and the child was transported to the hospital where she was pronounced dead around 4:45PM.

The medical examiner was notified and performed an autopsy. WCDSS requested a copy of the autopsy; however, the record did not reflect if it was received prior to the CPS investigation closing. Although no conversation with the medical examiner was documented, the Investigation Conclusion Narrative reflected the medical examiner stated there was evidence the subject child died due to asphyxia because of an unsafe sleeping environment, specifically, sleeping in an adult bed with the parents. Law enforcement was notified and began an investigation into the death. The outcome of the criminal investigation was unknown.

WCDSS made several home visits and interviewed the parents, as well as additional family members who had knowledge of the fatal event and could speak to the parents' overall care of the children. No concerns were expressed by family or other collaterals regarding the parents. The twin sibling was assessed to be safe in the parents' care and the grandparents'

3-year-old was assessed to be safe in their care.

Based on the information gathered throughout the investigation, WCDSS substantiated all allegations against the parents regarding the death of the child. The Investigation Conclusion Narrative incorrectly reflected the DOA/Fatality allegation was unsubstantiated against the mother. WCDSS concluded the child's death could not be attributed to a physical injury and despite prior counsel on the risk of co-sleeping, the parents co-slept with both children, with the addition of an aggravating factor present. The subject child's death was a result of the unsafe sleep environment, and the sibling was placed at risk of harm as she too was placed in the parents' bed.

Bereavement services were offered to the parents and a preventive services case was to be opened to assist with service delivery.

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

Explain:
All allegations alleged were substantiated, although the Investigation Conclusion Narrative incorrectly reflected the DOA/Fatality allegation was unsubstantiated against the mother.

Was the decision to close the case appropriate?	N/A
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:
A preventive services case was opened following the conclusion of the CPS investigation.

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: 06/26/2023 **Time of Death:** 04:45 PM

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

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	Aunt/Uncle	No Role	Male	18 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	3 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	42 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Month(s)

LDSS Response

On 6/26/23, WCDSS received two SCR fatality reports regarding the subject child. A third report was received 7/7/23. Upon receipt of the first two reports, WCDSS initiated their investigation within 24 hours by contacting the sources of the reports, reviewing CPS history, notifying the DA, interviewing the parents, and assessing the safety of the surviving sibling and other 3yo child who resided in the home.

WCDSS interviewed the parents at the police station immediately upon receipt of the reports on 6/26/23. The mother and father said on 6/25/23, they celebrated a friend's birthday at the family's home and their friends left around 1:00AM the morning of 6/26/23. The father had one drink of tequila but was not intoxicated. They both stayed up watching movies and the subject child and sibling were sleeping on the shared bed, between the parents. Around 5-6:00AM, the mother and father fed both children and went to sleep with the children in bed with them. The mother was on the outside, the sibling next to her, the subject child, then the father on the other side of the subject child. The father was the first to wake up, between 10:00AM and 12:00PM. The father checked on the children and said they were fine at that time, as they were observed asleep, but moving. He attempted to feed both children; however, only the sibling took the bottle. The mother was asleep, and the father went back to sleep at that time, not waking again until 3:30PM. At that time, the father tried to wake the subject child and she felt cold to the touch. She was laying faceup, with her eyes closed and the father observed a lot of mucus in her nose. He wiped the mucus from her nose and listened for breath sounds or a heartbeat, of which he heard neither. The father woke up the mother at that point and they brought the child upstairs from their basement bedroom so they could call 911. CPR was attempted at the direction of the 911 operator until emergency services arrived.

Records from emergency services revealed the subject child was in cardiac arrest upon arrival. Resuscitation was attempted; however, she presented in asystole. The child was transferred to the hospital at 4:44PM and pronounced dead in the emergency room. Birth records showed the child and sibling were briefly admitted to the Neonatal Intensive Care Unit as they were small for their gestational age. The mother had been diagnosed with intrauterine growth restriction during pregnancy and the children were delivered at 37 weeks following a motor vehicle accident. Pediatric records show both children were seen as recently as 6/21/23 for well-child visits and immunizations. A history of congestion was noted.

Immediately following the fatality, the sibling was brought to the hospital to have her breathing assessed. She was diagnosed with mild laryngomalacia and received referrals for multiple specialists, which included ENT, pulmonology, cardiology, genetic testing, and speech. WCDSS contacted the sibling's specialists and learned the mother was compliant with follow up appointments at the time the CPS investigation was closed.

Services were offered to the family. During the investigation, the family relocated to the maternal grandmother's home and were provided a Pack 'n Play for the sibling. Safe sleep was reviewed with the family. Both parents had participated in a CASAC evaluation, and it was learned the father tested positive for marijuana. Further assessment was recommended and both parents were referred for mental health services. Due to on-going service needs, a preventive case was opened. The CPS investigation was determined and closed on 8/24/23 and a Family Services Intake was opened to initiate services.

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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064288 - Deceased Child, Female, 2	064290 - Mother, Female, 20	DOA / Fatality	Substantiated

Mons	Year(s)		
064288 - Deceased Child, Female, 2 Mons	064290 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
064288 - Deceased Child, Female, 2 Mons	064291 - Father, Male, 22 Year(s)	DOA / Fatality	Substantiated
064288 - Deceased Child, Female, 2 Mons	064291 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
064289 - Sibling, Female, 2 Month(s)	064290 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
064289 - Sibling, Female, 2 Month(s)	064291 - Father, Male, 22 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	☒	☐	☐	☐

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 mother and father were referred for an evaluation with a CASAC, although a specific substance use concern was not documented prior to the referral. The father was positive for cannabis and further assessment was recommended. Neither parent met criteria for a substance use disorder. Both were recommended for mental health 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? No
Explain:
A service need specific to the fatality was not identified for the two-month-old sibling or the 3-year-old child who resided in the home at the time of the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Both the mother and father were provided with bereavement resources and referred to mental health providers, although neither had engaged in counseling services at the time the CPS investigation 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:

- [x] 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
- [x] 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