Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-056

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

Issue Date: Feb 22, 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: 7 month(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 10/01/2023
Initial Date OCFS Notified: 10/02/2023

Presenting Information

An SCR report alleged that on 10/1/23 around 8:00 PM, the mother fed the 7-month-old and put her down to sleep in the home. It was unknown where the mother placed the child to sleep or what the child's sleeping arrangements were. At an unknown time, the mother heard the child making abnormal noises which was described as "yipping." The mother checked on the child and found her unresponsive. It was unknown if the mother performed cardiopulmonary resuscitation and the mother did not contact 911. The mother ran with the child in her arms to a nearby hospital, which was .3 miles from the home and approximately an 8-minute walk. The mother arrived at the hospital with the child at 10:08 PM, at which point the child was unresponsive, had no pulse, and was not breathing. The child was pronounced deceased at 10:36 PM. The child was otherwise healthy and the mother had no explanation for the child's death.

Executive Summary

This fatality report concerns the death of a 7-month-old female child that occurred on 10/1/23. The investigation began after an SCR report was received that alleged Inadequate Guardianship and DOA/Fatality against the mother. The mother and child lived alone and the father resided in another state. The mother and father each had another child who both resided in another country and had no contact with the subject child.

On 10/2/23, Orange County Department of Social Services (OCDSS) learned of the death of the subject child and immediately began gathering information related to the incident. It was learned that two weeks before the death, the child began showing signs of illness, including a fever. The mother sought care for the child at an urgent care facility and was prescribed medication. The child was sick in the days leading up to the fatality, and the mother provided inconsistent accounts regarding when the child began showing symptoms. The mother reported to OCDSS that the child was having diarrhea on 9/27/23, and the mother informed the pediatrician's office of this during a well-child visit on the same day. The mother reported she was advised to give the child Pedialyte. The child was administered several immunizations during the appointment. The mother reported to hospital personnel that the child became ill the day after the well-child exam. OCDSS obtained medical records and interviewed the pediatrician, and the information received indicated the mother did not inform them of the child being ill, nor did they advise to give the child Pedialyte. Despite the timeframe inconsistencies, it was confirmed that in the days leading up to the death, the child was vomiting, had diarrhea, and was lethargic.

During the morning hours of 10/1/23, the mother brought the child to her church to participate in a religious blessing. When the mother and child returned home, the child was weak and lethargic, and the mother fed the child an adult nutrition supplement. The mother reported the child had 10 episodes of diarrhea and was vomiting throughout the day. Between 7:00 and 8:00 PM, the mother laid the child down on her back with her head propped. A couple of hours later, the mother reported she heard the child gasping, so she picked the child up, left the home, and attempted to run with her in her arms to a nearby hospital. A passerby saw the mother and child and transported them to the hospital where the child was pronounced deceased.

An autopsy was completed, and the final cause and manner of death were pending the results of additional tests. OCDSS obtained preliminary information, which indicated the child had a virus and gastrointestinal ailments at the time of her death. The child was severely dehydrated, and the medical examiner was inclined to say the child died because of her medical ailments and dehydration. Law enforcement determined there to be no criminality regarding the child’s death and closed their investigation.

OCDSS offered the mother bereavement counseling services and provided an application for assistance with the funeral arrangements; however, the mother moved to another state, and it was not believed she utilized the services. OCDSS added Lack of Medical Care against the mother, and all three allegations were substantiated. OCDSS concluded that the child was sick for several days and the mother did not obtain necessary medical care despite being capable of doing so. The preliminary autopsy showed the child died due to her medical ailments and severe dehydration. The investigation was indicated and closed on 12/1/23.

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?** N/A

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:
The mother and father each had a child who resided in another country. Neither child had visited with their respective parent since they moved to the United States in 2021. OCDSS documented diligent efforts to assess their safety; however, the completion of the safety assessment tools was not required. A determination was made in congruence with the evidence gathered throughout the investigation.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
The closure of the CPS investigation was appropriate, as all required casework activity was completed and the mother moved to another state.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 10/01/2023 **Time of Death:** 10:36 PM

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Other Household 1	Father	No Role	Male	42 Year(s)

LDSS Response

Upon receipt of the SCR report on 10/2/23, OCDSS initiated their investigation and coordinated efforts with law enforcement, notified the district attorney and medical examiner, interviewed the mother and collaterals, completed a home visit, and offered services regarding the fatality.

The mother was interviewed by OCDSS and OCDSS observed an interview of the mother by law enforcement. During these interviews, the mother reported she brought the child to the doctor for a well-child appointment on 9/27/23 and the child was given immunizations. The mother reported that she informed the doctor of the child's diarrhea and the doctor told her to get Pedialyte, but she did not have the money to do so. The child's vomiting and diarrhea continued from 9/27/23 to the time of the child's death on 10/1/23. The mother reported the child could not keep any fluids or food down and had excessive diarrhea. The mother was giving the child apple juice, water, and an adult nutrition supplement. The mother planned to get the Pedialyte on 10/2/23. The mother reported she brought the child to their church on 10/1/23 to be blessed by the pastor. The mother returned home and she last fed the child between 7:00 and 8:00 PM. The mother laid the child facing up and propped her head. Sometime before 10:00 PM, the mother heard the child gasping and rushed her to the hospital.

OCDSS requested medical records from the pediatrician's office and interviewed the doctor who treated the child on 9/27/23. The doctor denied any concerns brought to his attention regarding the child having diarrhea or being unwell. The

child was found to have lost a few ounces since her last appointment, and the doctor adjusted the child's feeding schedule and required the mother to bring her back for a follow-up in one week. The doctor reported that it was typical of them to advise a family to give their child Pedialyte when they are experiencing diarrhea but denied that the mother was told to do so. In addition, the doctor reported he would not have authorized the immunizations the child received if the mother reported the child was sick.

OCDSS interviewed members of the community who had contact with the family. One collateral reported seeing the child a few days before her death, and that while she seemed okay, she was sick. Another collateral reported that on 10/1/23, the child was sick and appeared to be asleep, but her eyes were slightly open.

OCDSS interviewed the father over the phone, who reported that he had regular video calls with the mother and child and had no concerns about the mother's care of the child. The mother had a 15yo child, and the father had a 17yo child, who remained in their country of origin when the mother and father relocated to the United States. OCDSS spoke to a maternal aunt and an adult sibling with whom the 15yo sibling had regular contact, and they reported no concerns for the sibling. OCDSS attempted to speak with the 17yo sibling and assess her safety virtually; however, the father had no contact information for her and OCDSS was not able to do so.

OCDSS interviewed all relevant family and collaterals, gathered medical records, and made diligent efforts to assess the safety of the siblings. Once all required casework activities were completed, OCDSS determined the allegations, supported by the information gathered during the investigation.

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
066168 - Deceased Child, Female, 7 Month(s)	066169 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
066168 - Deceased Child, Female, 7 Month(s)	066169 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
066168 - Deceased Child, Female, 7 Month(s)	066169 - Mother, Female, 37 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

Additional information:
The father resided in Florida and was interviewed over the phone. The two siblings resided in another country and OCDSS documented diligent efforts to interview them; however, were unsuccessful.

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?	☐	☐	☒	☐

Explain:
The mother had a 15yo child who resided in another country. OCDSS documented diligent efforts to have contact with that child; however, were unsuccessful. Relatives who had regular contact with the 15yo reported no safety concerns for him. The father had a 17yo child who resided in another country. OCDSS documented efforts to obtain contact information for her, which the father was unable to produce. The siblings had no contact with the subject child.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
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:
OCDSS offered bereavement services and funeral assistance to the mother. The mother left the state during the investigation and had not returned at the time the case 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? Yes

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.

Known CPS History Outside of NYS

A records clearance from Florida Department of Children and Families (DCF) was requested and received. The mother and child had no CPS history in the Florida DCF system.

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