Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-065

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

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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: 1 month(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 12/15/2023
Initial Date OCFS Notified: 12/18/2023

Presenting Information

An SCR report alleged that on 12/11/23 at approximately 1:00 PM, the mother was asleep with the 1-month-old female subject child in her arms. The mother woke up around 3:00 PM to find the child appearing apneic and unresponsive. The mother called 911 immediately. The child was transported to the hospital and admitted to the intensive care unit. The mother had no explanation for the child's condition. The child died in the hospital on 12/15/23. The cause of death was severe hypoxic brain injury leading to brain death after post-cardiac arrest at home. The child's death occurred after being placed in an unsafe sleeping arrangement by the mother. The roles of the grandparents and the father were unknown.

Executive Summary

On 12/11/23, the Westchester County Department of Social Services (WCDSS) received an SCR report regarding the 1-month-old child becoming unresponsive after the mother fell asleep while holding the child. The report alleged Inadequate Guardianship against the mother and maternal grandparents. The child was hospitalized following the incident, where she remained on life support until the time of her death on 12/15/23. On 12/19/23, an SCR report alleged the child died due to an unsafe sleep environment. The report alleged DOA/Fatality, Inadequate Guardianship, and Internal Injuries against the mother. The child resided with the mother and maternal grandparents. The father resided outside of the home and had infrequent contact.

WCDSS investigated the fatality by interviewing the family, speaking to collaterals, and gathering pertinent medical records. On 12/11/23, the mother and child were at home with the grandparents. The grandparents saw the mother tending to the child before they left the home between 1:30 PM and 2:30 PM. The mother reported she was sitting in a rocking chair feeding the child in her arms and then rocked the child to sleep. The mother intended to place the child in her bassinet once asleep, though fell asleep herself before she could do so. The mother woke up shortly thereafter and found the child blue and unresponsive in her arms. The mother called 911 and then alerted her family. First responders arrived and the child was taken to one hospital, then transferred to another to get the medical attention she needed. The child remained in the hospital from 12/11/23 through 12/15/23, where she remained sedated, on a ventilator, and intubated. It was determined the child was brain dead and the parents decided to withdraw the child from respiratory support which led to her passing.

An autopsy report was completed and the final results were pending at the time this report was written. Preliminary results were discussed with the medical examiner and indicated the child died due to asphyxiation due to unsafe sleep practices. Law enforcement investigated the fatality and their investigation was open pending receipt of the final autopsy report.

WCDSS unfounded the allegations against the maternal grandparents and the mother. WCDSS determined that the evidence gathered revealed that the death of the child was not related to any physical injury resulting from physical abuse. Though the medical examiner stated that the child’s death was related to asphyxiation due to unsafe sleep practices while in the mother’s care, WCDSS did not discover any aggravating factors to support that the mother was negligent. WCDSS concluded that the mother's actions of rocking the child to sleep while on a rocking chair and accidentally falling asleep was not a neglectful act, and the mother had no intention of falling asleep with the child. Fatality-related services were offered to the family and accepted by the mother. The investigation was unfounded and closed on 2/16/24.

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:
There were no surviving siblings or children in the home; therefore, the completion of the safety assessment tools was not required. WCDSS supported their determination with the evidence gathered during 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:
Casework activity was commensurate with 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: 12/15/2023 **Time of Death:** 01:54 PM

Date of fatal incident, if different than date of death: 12/11/2023
Time of fatal incident, if different than time of death: 02:30 PM

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: 02:48 PM
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	1 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	71 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	67 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Other Household 1	Father	No Role	Male	29 Year(s)

LDSS Response

WCDSS received the SCR report regarding the fatal incident on 12/11/23 and began gathering information. On 12/15/23, the child was removed from life support and died. WCDSS notified OCFS via the 7065 Agency Reporting Form. An SCR report regarding the death was received on 12/19/23. WCDSS spoke with law enforcement and notified the medical examiner's and district attorney's offices of the death.

WCDSS interviewed the mother, who was accompanied by an aunt and the grandparents during the interview. The mother reported on the day of the incident she was sitting in the rocking chair, as the child loved being rocked. The mother fed the child at 2:30 PM, and stated she must have fallen asleep. The mother woke up cradling the child, who was blue and unresponsive. The mother reported the child was facing up toward her and when she woke, the child's face was positioned into her breast. The mother reported no medical concerns for the child, other than an allergy to milk, which the mother addressed with the pediatrician. The mother reported it was typical for her to feed and rock the child to sleep, then place her in the bassinet.

WCDSS interviewed the grandparents at their home. The grandparents reported that on the day of the incident, the mother cared for the child as she normally would. Between 1:30 and 2:30 PM, the grandparents left the home. The grandmother saw the mother feeding the child before her departure. The grandparents were informed by the mother that while she was feeding the child she fell asleep, and woke up to the child unresponsive. The grandparents reported no concerns for the mother's care of the child. The child slept in a bassinet in the mother's bedroom. The child had no known medical concerns and the grandparents reported she was very well cared for.

WCDSS documented diligent efforts to interview the father; however, he did not respond to WCDSS' attempted contact. The father was notified of the SCR report in writing. WCDSS obtained medical records, which revealed the child was up to date with medical appointments and there were no concerns noted for her care. The mother's account of events reported to medical personnel were consistent with information obtained by WCDSS. WCDSS offered fatality-related services, which the mother enrolled in following the child's death. Once all casework objectives were accomplished, WCDSS unfounded and closed 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
067008 - Deceased Child, Female, 1 Month(s)	067015 - Grandparent, Male, 71 Year(s)	Inadequate Guardianship	Unsubstantiated
067008 - Deceased Child, Female, 1 Month(s)	067016 - Grandparent, Female, 67 Year(s)	Inadequate Guardianship	Unsubstantiated
067008 - Deceased Child, Female, 1 Month(s)	067014 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
067008 - Deceased Child, Female, 1 Month(s)	067014 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
067008 - Deceased Child, Female, 1 Month(s)	067014 - Mother, Female, 29 Year(s)	Internal Injuries	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?	☒	☐	☐	☐
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:
WCDSS documented multiple attempts to interview the father. He resided out of state and did not respond to WCDSS' attempted contact.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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 was enrolled in mental health services following the child's death.

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.

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