Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-100

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

Issue Date: Jan 28, 2025

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: 1 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 10/21/2024
Initial Date OCFS Notified: 10/21/2024

Presenting Information

An SCR report received on 10/21/24 alleged that the mother fed the subject child at 8:00AM on that same date. The mother then left the child face-up on an adult-sized bed and left the room to feed the sibling. The child was in an unsafe sleep environment and unsupervised until 9:00AM. When the mother returned to the room, the child was face-down on the bed and not breathing. It was unknown what bedding was around the child at the time of her death.

Executive Summary

This report concerns the death of the 1-month-old subject child. The Administration for Children's Services (ACS) received an SCR report regarding the child's death on 10/21/24. At the time of her death, the child resided with her mother, father, and 4-year-old sibling.

The morning of 10/21/24, around 8:30AM, the mother had been in bed with the sibling and took the subject child out of her crib, placing her on the bed to breastfeed. About 30 minutes later, around 9:00AM, the sibling voiced she was hungry. The mother swaddled the subject child in a receiving blanket and placed her on her side on the adult-sized mattress. The mother left the bedroom with the sibling and went into the kitchen to prepare food. Around 9:30AM, the mother went back into the bedroom to check on the child and observed the child laying face-down to the right, with her mouth open. The right side of the child's face was purplish blue in color, and she was not breathing. The mother contacted 911 and was provided guidance on how to perform cardiopulmonary resuscitation (CPR). Emergency medical services (EMS) arrived at the home and took over life-saving efforts. EMS transported the child to the hospital where resuscitation efforts continued for an additional 29 minutes to no avail. The child was pronounced deceased at the hospital at 10:23AM.

The medical examiner was notified; however, the family declined an autopsy. As such, the medical examiner stated the cause of death would be undetermined. Hospital staff report no marks or bruises or any signs of trauma to the child. Law enforcement investigated and no charges were brought in relation to the death.

ACS made several home visits and interviewed the mother, father, family members, and relevant collaterals. The sibling was assessed to be safe in the parents' care.

ACS substantiated all allegations contained in the SCR report against the mother. ACS concluded there was a fair preponderance of evidence to substantiate Inadequate Guardianship and Lack of Supervision as the mother had knowledge of safe sleep recommendations; however, placed the child in an unsafe sleep environment by swaddling the child, propping a pillow behind her back (a fact not noted in the mother's account nor law enforcement's account of the re-enactment; therefore, it was unclear where that piece of information was learned), and leaving the room for a reportedly unknown amount of time (though reported by the mother to be 30 minutes). The Investigation Conclusion Narrative went on to say DOA/Fatality was unsubstantiated as the mother did not cause physical harm to the child, the medical examiner could not determine causation, and law enforcement found no foul play. The CONNECTIONS record; however, reflected DOA/Fatality was substantiated. Due to discrepancies in the conclusion narrative not coinciding with the chosen allegation outcomes, it was unclear if ACS intended to substantiate DOA/Fatality. Supervisory notes differed, in that one note reflected all allegations should be substantiated, and another note reflected only Inadequate Guardianship and Lack of Supervision should be substantiated. This discrepancy led to the Risk Assessment Profile being scored

inaccurately if the intent was in fact to substantiate DOA/Fatality. Overall, the investigation was accurately indicated.

The mother accepted a preventive services referral for the family and had engaged in bereavement counseling prior to the CPS investigation closing.

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?** Yes

Explain:

Overall, it was appropriate to indicate the investigation as the mother placed the child in an unsafe sleep environment and left the child unattended for a period of time, during which the fatal incident occurred. However, the outcome of the DOA/Fatality allegation was unclear as the record reflected the intent to both substantiate and unsubstantiate the allegation.

Was the decision to close the case appropriate? N/A

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:
As the family accepted a preventive services referral, ACS opened a family services stage (FSS) and the case remained open for ongoing services.

Required Actions Related to the Fatality

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

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	Supervisory notes reflected DOA/Fatality should be both substantiated and unsubstantiated. The CONNX record reflected the allegation as substantiated, but the Investigation Conclusion Narrative reflected unsubstantiated, making unclear ACS's intent.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/21/2024 **Time of Death:** 10:23 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: 09:33 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	1 Month(s)
Deceased Child's Household	Father	No Role	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)

LDSS Response

On 10/21/24, ACS received a report regarding the death of the subject child. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history check regarding the family, which revealed no prior child welfare history, and informed the DA of the fatality. ACS assessed the safety of the sibling and conducted routine home visits throughout the open investigation.

ACS interviewed the parents regarding the events leading up to the child's death. The morning of 10/21/24, the father left the home around 7:00AM for work and the child was in her Pack 'n Play. Around 8:30AM, the mother reported being in bed with both children, but awake. The mother had picked the child up from what she reported as a crib and placed the child on the bed to feed her. Around 9:00AM the sibling told the mother she was hungry, at which point the mother placed the subject child on the bed, positioned her on her side swaddled in a receiving blanket. The mother stated she placed the child on her side because she had not burped after feeding. There was no mention of placing a pillow at the child's back, as mentioned in the Investigation Conclusion Narrative. The mother then left the room and went into the kitchen, bringing the sibling with her. While in the kitchen, the mother was on the phone with her sister and next checked on the child around 9:30AM. When the mother entered the room, she observed that the child was laying with her mouth open with her right side on the bed. The right side of the child's face was discolored, and she was not breathing. The mother put her ear to the child's chest and heard a heartbeat. Law enforcement's interview reflected the mother periodically checked on the child while away from the bedroom and it was during the second check the mother found the child unresponsive. The mother called the father who told her to call 911, which she did. The father met the mother at the hospital, at which point he learned of the child's death. The father reported the entire family shared a bed at times, though this was not further explored. ACS observed the sibling did not have her own bed and provided one to the family.

ACS spoke to the medical examiner, but the family declined an autopsy. Hospital staff reported the child had no pulse on arrival. Law enforcement and the medical examiner investigator completed a re-enactment with the mother, reporting a similar account of what the mother reported. The child's sleep environment was at times referred to as a crib, bassinet, or Pack 'n Play; all of which would be considered safe sleep environments given the child's age.

ACS contacted numerous collaterals including law enforcement, the hospital, the medical examiner, relatives close with the family, the sibling's daycare, and the sibling's pediatrician. Law enforcement reported speaking with the subject child's medical providers and the child had no medical concerns, except a rash. ACS assisted the family with obtaining furnishings and advocated to the landlord to address the need for window guards and carbon monoxide detectors, which were all promptly installed. At the close of the investigation, the sibling was deemed safe, and no criminal charges were brought. The report was indicated and an FSS was opened for preventive services.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: Undetermined if injury or medical cause

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: There is no Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069950 - Deceased Child, Female, 1 Month(s)	069951 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
069950 - Deceased Child, Female, 1 Month(s)	069951 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
069950 - Deceased Child, Female, 1 Month(s)	069951 - Mother, Female, 32 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐
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?	☒	☐	☐	☐

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	☒	☐	☐	☐

Explain:
The RAP was not completed accurately, based off the CONNECTIONS record, with reflected DOA/Fatality being substantiated. However, the overall record was unclear if DOA/Fatality was meant to be substantiated or not as it was documented multiple ways.

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 at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☒	☐	☐	☐	☐	☐

Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The sibling was referred for an evaluation; however, no services were recommended. The mother was informed the sibling could be re-referred if the mother noticed behavioral changes in the sibling following the death.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The mother engaged in bereavement counseling following the death, which she stated she found helpful. The mother also accepted a preventive services referral and was engaged in preventive services through a contract agency prior to the CPS case closing.

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