Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-100

Prepared by: New York City Regional Office

Issue Date: May 16, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/01/2022
Initial Date OCFS Notified: 12/01/2022

Presenting Information

An SCR report was received on 12/1/22 and alleged that approximately three weeks prior the mother and father took the 2-month-old subject child to the hospital for flu-like symptoms. The child was examined and sent home with the parents, who were told it was probably just a cold or the flu. The child continued to be ill with flu-like symptoms and the parents did not seek further medical care. On 12/1/22, the mother went to feed the child and he would not wake up. The parents called 911 around 4:20 AM. Emergency medical services responded to the home and transported the child to the hospital, where he was pronounced deceased at 5:08 AM. The roles of the four other adults and the sibling in the home were unknown.

Executive Summary

On 12/1/22, the Administration of Children's Services (ACS) received an SCR report regarding the death of a 2-month-old male child that occurred on the same date. The report alleged DOA/Fatality, Lack of Medical Care, and Inadequate Guardianship against the mother and father regarding the subject child. At the time of the death, the child resided with his mother, father, 6-year-old sibling, two aunts, and uncle. Upon receipt of the SCR report, ACS assessed the safety of the sibling and determined there were no concerns.

ACS conducted a joint investigation with law enforcement and learned that since the child was born, the parents had brought him for medical care several times due to concerns for flu-like illness. Each time, the child was seen, his nose was suctioned due to congestion, and the family was sent home. The child was not prescribed medicine nor was any testing performed. On 11/30/22, the mother fed the child and placed him to sleep in a toddler bed, which was positioned at the foot of the mother's bed. The mother woke up around 3:00 AM to feed the child and when she picked him up discovered he was unresponsive. The father was asleep in a separate bedroom and was woken by the mother screaming. The uncle called 911 and the parents attempted cardiopulmonary resuscitation. First responders arrived and transported the child to the hospital where he was pronounced deceased.

An autopsy was completed; however, the final cause and manner of death had not yet been determined at the time this fatality report was written. ACS spoke with the medical examiner, who reported the child tested positive for Respiratory Syncytial Virus (RSV). The medical examiner further stated that there were no concerns for maltreatment and that the preliminary cause of death was that the child's RSV was not treated properly. ACS spoke with law enforcement and learned that there was no criminality detected regarding the death.

The parents reported that they had brought the child to the hospital five times since his birth due to concerns for him being sick. The parents stated they would be seen, the child's nose would be suctioned and they would be sent home. The child was due to have a follow-up on the day of his death. Though ACS documented they requested the hospital records, there was no information gathered from medical collaterals to determine if the parents had brought the child for medical attention or if there were any recommendations for the child's medical care. In addition, the record did not reflect that the two aunts and the uncle were interviewed or notified of the report.

ACS held a child safety conference to assess the safety of the surviving sibling. The recommendations of the conference were that the sibling be referred to early intervention, and the family be referred to grief counseling, family counseling, provided with food assistance, and a daycare voucher. ACS opened a preventive services case, as the parents were initially receptive to ongoing services; however, they then declined to participate and requested the case be closed. The service

recommendations were provided to the parents. The CPS investigation had not yet been determined at the time this fatality report was written.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The investigation had not yet been determined at the time this report was written.

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:
The record did not reflect that all required casework activity was completed as identified in the included citations.

Required Actions Related to the Fatality

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

Issue:	Adequacy of services following the fatality
Summary:	The record reflected that the family requested assistance with the funeral arrangements and it was not documented that assistance was offered.

Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	ACS will explore areas of potential service needs with all family members with whom they are involved. ACS will appropriately respond to changing circumstances, and if service needs are identified, ACS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect ACS gathered information from medical collaterals to determine if the child had received any medical care.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.
Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	There were two aunts and an uncle listed on the household composition and the record did not reflect attempts to interview them and notify them of the report in writing.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/01/2022 **Time of Death:** 05:08 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: 04:20 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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	30 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	32 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	31 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)

LDSS Response

Upon receipt of the SCR report on 12/1/22, ACS initiated their investigation, coordinated efforts with law enforcement, sent notification to the Medical Examiner and District Attorney, interviewed the parents, assessed the safety of the sibling, and offered referrals for services.

ACS interviewed the mother who reported that on the evening of 11/30/22, the child and family were at their home. The mother fed the child around 11:00 PM and then placed him to sleep in a toddler bed. The toddler bed was positioned at the foot of the mother's bed. The child was placed to sleep on his back and on top of a pillow. The mother reported the child typically co-slept with her because he was fussy and would cry due to not feeling well. The evening of 11/30/22 was the first time the child had slept in the toddler bed. The mother typically woke every three hours to feed the child. On 12/1/22 around 3:00 AM, the mother woke up and when she picked the child up to feed him, he was unresponsive and not breathing. The mother alerted the father and attempted CPR.

The father was interviewed and confirmed the child was placed to sleep in his toddler bed after being fed by the mother. The father was in a separate bedroom and shared a bunk bed with the sibling. The father was woken by the mother who he reported was frantic and devastated by their child being unresponsive. The father went downstairs to get the uncle and the uncle called 911. The family attempted CPR before first responders arrived and brought the child to the hospital.

ACS gathered information from law enforcement, who reported that the parents provided a similar account of events as they did to ACS. Law enforcement had no concerns for the condition of the home. In speaking with the medical examiner, law enforcement was informed the cause of death may have been congenital heart failure; however, the final cause of death was pending further testing. ACS completed a visit to the home and the family had appropriate provisions for the sibling. There was no appropriate sleeping environment for the subject child and it was not clear if the parents were aware of safe sleep guidelines. ACS documented there were no concerns for substance use during their interviews with the parents. The sibling's school reported no concerns for the sibling other than a language barrier, as the family was Spanish speaking. During ACS' initial contact with the sibling, he refused to speak with CPS.

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: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063314 - Deceased Child, Male, 2 Mons	063315 - Mother, Female, 22 Year(s)	DOA / Fatality	Pending
063314 - Deceased Child, Male, 2 Mons	063315 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Pending
063314 - Deceased Child, Male, 2 Mons	063315 - Mother, Female, 22 Year(s)	Lack of Medical Care	Pending
063314 - Deceased Child, Male, 2 Mons	063316 - Father, Male, 26 Year(s)	DOA / Fatality	Pending
063314 - Deceased Child, Male, 2 Mons	063316 - Father, Male, 26 Year(s)	Inadequate Guardianship	Pending
063314 - Deceased Child, Male, 2 Mons	063316 - Father, Male, 26 Year(s)	Lack of Medical Care	Pending

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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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 attempted to speak with the sibling; however, he refused to participate in the interview.

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:
Due to a prior domestic incident in which the father perpetrated against the mother, ACS offered domestic violence services; however, the mother declined. The family expressed a need for assistance with the funeral arrangements and the record did not reflect assistance was offered. The family declined grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No

Were there any siblings ever placed outside of the home prior to this child's death? 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

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