Child Fatality Report

Report Identification Number: NY-23-014

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: 29 day(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 01/24/2023
Initial Date OCFS Notified: 01/25/2023

Presenting Information

The Administration for Children's Services (ACS) received an SCR report on 1/25/2023 which alleged the mother (SM) placed the 1-month-old child (SC) down for a nap at an unknown time. At approximately 10:00 PM, the mother checked on the child and found him unresponsive and bluish in color. The mother called 911 and EMS initiated CPR upon their arrival. The child was brought to the hospital where he was pronounced dead. The child was alleged to have been otherwise healthy and the mother had no explanation for his death. The role of the father was unknown.

Executive Summary

This report concerns the death of a 1-month-old child which occurred while in the care of his mother. ACS received the report and coordinated their response with law enforcement and hospital staff.

Upon their arrival to the hospital, ACS was informed the mother placed the child to sleep in an adult bed at approximately 8:00 PM and fell asleep next to him. The mother awoke at approximately 10:00 PM and the child was unresponsive and bluish in color. The mother called 911 and left the child in the bed until EMS arrived and attempted life-saving interventions. The child was transported to the hospital and pronounced dead at 10:51 PM.

The mother declined to be interviewed by ACS throughout the investigation. The mother communicated with ACS through an email in which she admitted she placed the child facedown on a memory foam mattress and fell asleep next to him. The mother acknowledged she was aware of safe sleep guidelines but did not follow them. The mother declined to assist ACS in their investigation.

ACS obtained information from the medical examiner. The medical examiner stated an autopsy was completed and preliminarily there were no signs of abuse or trauma. The child was placed on his stomach in an adult bed and the mother co-slept with him prior to waking and finding him unresponsive. The final autopsy report was pending at the time the investigation was closed.

A referral for services was made on behalf of the mother, though she stated she would decline services. The allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the deceased child were substantiated and the investigation was closed.

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?** 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:
The decision to close the case was made commensurate with the case circumstances.

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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the 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: 01/24/2023 **Time of Death:** 10:51 PM

Time of fatal incident, if different than time of death: 10:00 PM

County where fatality incident occurred: Bronx
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? 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	Male	29 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)

LDSS Response

ACS received the SCR report and coordinated their response with LE and hospital staff. Hospital staff informed ACS the SM placed the SC in the adult bed at approximately 8:00 PM and fell asleep next to him. The SM awoke at approximately 10:00 PM and found the SC unresponsive. LE interviewed the SM immediately following the incident separate from ACS.

ACS visited the SM at her home. The SM allowed ACS into the home, though she declined to speak about the SC's death. ACS observed the bedroom in which the incident occurred and were shown the room by a friend of the SM's (OA). The OA disclosed to ACS the SM had dropped the SC earlier in the day of the fatal incident and did not believe he was injured. ACS made multiple attempts throughout the investigation to interview the SM regarding the fatal incident, which she declined to participate in. The SM declined to complete a drug screen or sign releases for ACS to obtain information from the SC's providers. The SM sent ACS an email in which she admitted she placed the child face down on a memory foam mattress and fell asleep next to him. The SM admitted to having knowledge of safe sleep practices which she did not follow.

ACS made multiple efforts to locate the BF and inform him of the report. No attempts to locate the BF were successful.

The SM had two older children who were in the custody of the maternal grandmother (MGM). The surviving half siblings (SSs) were assessed as safe in the care of the MGM and a referral for bereavement counseling was made on their behalf. The SSs had no knowledge of the fatal incident and were not added to the case record.

EMS responders were interviewed regarding the fatal incident. EMS stated they responded to the home and found the child on the bed. CPR was initiated and the SC was transported to the hospital. EMS described the SC had lividity in his torso upon their arrival.

ACS obtained information from the ME's office. The ME stated the preliminary autopsy result showed no signs of abuse, trauma, or injury. The ME stated that what she was most concerned about and believes may be the reason for the child's death is that the child was found face-down and belly-down. The SM called 911 and left the SC on the bed until EMS arrived. The final autopsy report was pending at the time the investigation closed.

ACS made multiple attempts to obtain information regarding the criminal investigation from LE. LE did not return any of their contact attempts. The status of the criminal investigation was unknown at the time ACS closed their investigation.

The allegations of DOA/Fatality and IG against the SM regarding the SC were substantiated. A referral for services was made on behalf of the SM by ACS, though it was unknown from the case record if she utilized the 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? No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064128 - Deceased Child, Male, 29 Days	064129 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
064128 - Deceased Child, Male, 29 Days	064129 - Mother, Female, 32 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?	☒	☐	☐	☐

Additional information:
The SM declined to be interviewed and the BF was unable to be located.

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	☐	☐	☐	☐	☐	☒	☐

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? Unable to Determine
Explain:
A referral for services for the SSs was made, though it was unclear if the services were utilized.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SM declined bereavement services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/20/2023	Deceased Child, Male, 27 Days	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
The SCR report alleged the SM gave birth to the SC on 12/26/2022 and had two other children removed from her care.

Report Determination: Indicated | **Date of Determination:** 03/22/2023

Basis for Determination:
At the time ACS was seeing the SC at the hospital, an allegation was made that the SM swung the SC in a car seat, potentially causing harm to the SC. The SC was seen and evaluated as having no medical concerns and the SM stated that she did not swing the car seat, but instead lifted it to carry while attempting to rush inside before it started to rain. There were no concerns identified at the time of the report for the SC in the SM's care. The SC died during the open investigation and the fatality investigation was conducted concurrently with this open investigation. ACS made diligent efforts to locate and contact the BF.

OCFS Review Results:
ACS conducted an investigation which met regulatory requirements. Information was obtained from relevant collateral sources and a determination of the allegations was made in congruence with the evidence gathered.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

The SM was the subject of 3 substantiated reports dating back to 2/2016 with allegations of drug misuse and lighting a couch on fire during an argument with the MGM in 2019. The SSs were placed in the care of the MGM in 3/2016.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

Services were put in place to support the SM when she misused drugs and to support the MGM while caring for the SSs. Services were provided from 2/2019-6/2020 and 3/2016-2/2019. The SSs were placed in the care of the MGM in 3/2016.

Foster Care Placement History

The SSs were placed in the care of the MGM in 3/2016. The SSs were placed in her care due to the concerns for the SM's drug misuse and concerns for her mental health. The SSs remained in the care of the MGM at the time this report was written, though no services were being provided or monitored by ACS.

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