Report Identification Number: NY-23-030

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

Issue Date: Aug 25, 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		

Office of Children and Family Services

Child Fatality Report

Case Information

Report Type: Child Deceased
Jurisdiction: Richmond
Date of Death: 03/08/2023
Age: 2 month(s)
Gender: Male
Initial Date OCFS Notified: 03/08/2023

Presenting Information

An SCR report alleged on 3/7/23, around 11:00 PM, the mother and her partner (parent substitute) went to sleep with the 2-month-old infant in their bed. On 3/8/23, the parent substitute woke up around 9:00 AM, checked on the infant, and went back to sleep. Between 11:00 AM and 11:30 AM, the mother and parent substitute observed the infant was not breathing and was blue in color. The parent substitute's mother called 911 and attempted CPR. The infant was transported to the hospital at 12:24 PM. He was noted to have no pulse, no respirations, was cool to the touch, and his temperature was 80 degrees. The infant was pronounced deceased on 3/8/23 at 12:45 PM. The mother and parent substitute's timeline was inconsistent as there was pooling of blood on the infant's skin surface. The unsafe sleeping conditions contributed to the infant's death.

Executive Summary

On 3/8/23, the New York City Administration for Children's' Services (ACS) received an SCR report regarding the death of the 2-month-old male infant that occurred on that date. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the mother and parent substitute. At the time of the infant's death, the infant resided with his mother and the parent substitute in the state of New Jersey (NJ). New Jersey Division of Child and Family had an open investigation at the time of the infant's death, dated 12/30/22, due to the mother and infant testing positive for marijuana at the time of the infant's birth.

ACS and law enforcement conducted a joint investigation into the infant's death. It was learned that the mother, parent substitute, infant, and the parent substitute's mother were visiting the parent substitute's father's home in Richmond County, NY for the weekend. On the night of 3/7/23, the mother and parent substitute fed the infant a bottle at approximately 11:00 PM, then they co-slept with the infant on a full-size bed. The parent substitute reported waking up around 9:00 AM and saw that the infant was still sleeping so he went back to sleep. At approximately 11:00 AM, the mother and parent substitute awoke and observed the infant to be lying between them on his back and he was unresponsive and blue. They yelled for the parent substitute's mother, who entered the bedroom, called 911, and began CPR. EMS arrived, began life-saving measures, and transported the infant to the hospital via ambulance. Efforts to resuscitate the infant were unsuccessful and the infant was pronounced deceased at 12:45 PM on 3/8/23.

Hospital staff reported they observed the mother and parent substitute to appear under the influence of an unknown substance in that they were drooling, foaming at the mouth, and had slurred speech. Law enforcement reported that the mother and parent substitute appeared to be under the influence when they responded to the home. The adults' eyes were closing, they were moving slow and slurring their words, and the parent substitute was frothing at the mouth. Law enforcement found a white powder in the bedroom where the infant died, which tested positive for Oxycodone, Cocaine, Methamphetamine, and MDMA. The parent substitute was awaiting sentencing for drug related charges at the time of the infant's death and was remanded to jail after drugs were found in the home.

An autopsy was performed, and the final results were pending at the time this report was written. The medical examiner said the child did not have any fractures, internal bleeding, or injuries. Based on the settling of blood around the child's face, left side of the body and chest, and small hemorrhage by the left eye, it was believed the child was not sleeping on his back as reported and the infant had been deceased longer than reported. It was additionally stated that fluid on the bed sheets was indicative of the infant sleeping face down. The law enforcement investigation remained open pending the final autopsy results.

The father of the infant was incarcerated for unrelated charges. The father was spoken to on the phone, and he had no details about the death. He reported that he had a second child who resided with the child's mother and had no relationship with the infant. ACS assessed the child to be safe in her mother's care.

ACS substantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother and parent substitute based on the concern they were under the influence of an unknown substance at the time of the fatal incident, which impaired their judgement. Both adults admitted to co-sleeping with the infant and the parent substitute admitted to falling sleep with the infant cradled in his arm. The mother had been previously educated on safe sleep guidelines and the dangers of co-sleeping. ACS and NJ CPS offered bereavement services to the mother and parent substitute, and they declined.

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:
Safety Assessments were not required as there were no other children residing in the infant's home or in the care of the mother and parent substitute. The father's other child did not have a relationship with the infant. The case was appropriately indicated and closed.

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: 03/08/2023 **Time of Death:** 12:45 PM

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

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: 12:01 PM
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	Male	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	36 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)
Other Household 2	Other Adult - Parent Substitute's Mother	No Role	Female	60 Year(s)

LDSS Response

ACS investigated the child’s death by contacting the source of the report, reviewing SCR history, and referring the infant’s death to the DA’s office. ACS conducted visits to the hospital and parent substitute’s father’s home, and interviewed the mother, parent substitute, and parent substitute’s parents. ACS spoke to hospital staff, law enforcement, the medical examiner, neighbors, family members, and they coordinated efforts with NJ CPS. ACS confirmed the mother had a 6-year-old child that was adopted by the maternal grandfather, and they assessed the child to be safe.

ACS interviewed the mother and parent substitute upon receipt of the SCR report on 3/8/23. The mother and parent substitute did not appear to be under the influence at that time, and they denied using any drugs or other substances while visiting the home that weekend. The mother reported that the infant was healthy and had been eating and acting normal. The mother and parent substitute reported that on 3/7/23, the parent substitute’s mother babysat the infant from 6:00 PM until around 9:00 PM, while they went to the store. At approximately 11:00 PM, they fed the infant a bottle, then they went to sleep with the infant cradled in the parent substitute’s right arm and the mother lying on the parent substitute’s left side. At 9:00 AM the parent substitute awoke and observed the infant to be sleeping on his back in between them, at an angle

with his face turned to the right. He went back to sleep until 11:00 AM, when he awoke and observed the infant still lying in the same position, but he was blue in color, cold to the touch, and unresponsive. The mother and parent substitute yelled for the parent substitute's mother, who entered the bedroom, called 911 and began CPR.

The parent substitute's mother reported that she resided in NJ and had custody of the parent substitute's 13-year-old child since 2012. ACS determined the parent substitute had no contact with his 13-year-old child and the child was assessed to be safe in the KinGap custody of the parent substitute's mother. The parent substitute's mother said she spent the weekend at the parent substitute's father's home and assisted with caring for the infant. The parent substitute's parents said that the infant appeared to be healthy, and he was acting normal. There was no crib in the home for the infant, so he had been co-sleeping with the adults. They said the mother and parent substitute had a history of drug use; however, the mother and parent substitute appeared to be sober all weekend. The parent substitute's mother said she babysat the infant on 3/7/23 from around 6:00 PM until 8:00 PM while the mother and parent substitute did errands. When the mother and parent substitute returned, they took the infant into the bedroom and laid him on the bed. The parent substitute's parents reported the next morning, they heard screaming and the parent substitute's mother went to see what was wrong. She saw the infant lying on his back on the bed, and he was blue and not moving. She called 911 and performed CPR until EMS arrived and took over.

EMS records showed the 911 call was received at 12:01 PM and the infant was in cardiac arrest upon arrival to the home. Hospital staff reported the infant had no pulse and was showing signs of lividity upon arrival to the hospital at 12:21 PM. Hospital staff said the infant's body temperature was 80 degrees, which would have taken a few hours to occur, and was inconsistent with the parent substitute's timeline.

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
064489 - Deceased Child, Male, 2 Mons	064490 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
064489 - Deceased Child, Male, 2 Mons	064490 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
064489 - Deceased Child, Male, 2 Mons	064491 - Mother's Partner, Male, 36 Year(s)	DOA / Fatality	Substantiated
064489 - Deceased Child, Male, 2 Mons	064491 - Mother's Partner, Male, 36 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 father of the infant was interviewed over the phone in jail.

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 parent(s) and other care givers to address any immediate needs related to the fatality? No

Explain:

The parents declined services.

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

An SCR report dated 10/27/16 was UNF against the parent substitute and his mother for the allegations of DOA/Fatality, IG and LMC regarding an other child not related to this fatality investigation. A child died in 2008 from natural causes and the parent substitute and his mother were determined not to be caretakers for the child. Allegations of IG, LMC and PD/AM were Unsub against the parent substitute and his mother regarding the parent substitute's now 13-year-old child. The PS's now 13-year-old child was in the custody of the parent substitute's mother since 2012.

Known CPS History Outside of NYS

The mother had extensive CPS history in NJ since 2016. The mother had a child removed from her custody in 2017 due to drug misuse and neglect. The child was placed with the maternal grandparents and adopted by the maternal grandfather in 2022. NJ CPS had an open investigation at the time this report was written, dated 12/30/22, due to the infant and mother testing positive for marijuana at the time of the infant's birth. NJ CPS met with the mother and infant's father, who appeared to be sober and coherent, and they agreed to cooperate with the investigation. CPS learned that the mother tested positive for drugs during her pregnancy with the infant. CPS arranged for a registered nurse to monitor the infant after discharge home to the mother, and they went over safe sleep guidelines with the mother. The father of the infant was arrested on unrelated charges in January 2023 and the mother stopped cooperating with NJ CPS. She did not answer phone calls or meet with NJ CPS during the month of February 2023, and attempts to locate the mother were unsuccessful.

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