Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-034

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

Issue Date: Jun 30, 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		

Case Information

Report Type: Child Deceased

Jurisdiction: Office Of Special Investigations

Date of Death: 03/29/2023

Age: 3 year(s)

Gender: Male

Initial Date OCFS Notified: 03/29/2023

Presenting Information

An SCR report received on 3/29/23 alleged that between 3:00 and 4:00AM, the mother and the mother's partner fed the subject child and placed him in his crib to sleep. The partner checked on the subject child at approximately 10:30AM and the child was found face down, on his stomach, and not breathing. The child's body appeared discolored. The partner called 911. It was alleged the mother was present throughout the incident, but it was unknown what actions the mother took. Emergency medical services were unable to perform cardiopulmonary resuscitation (CPR) because the child's body was in rigor mortis. The child was pronounced deceased at 11:03AM. The child was alleged to be an otherwise healthy child and the mother and partner did not have an explanation for the child's death.

Executive Summary

This fatality report concerns the death of the 3-year-old subject child. The Administration for Children's Services (ACS) received an SCR report regarding the child's death on 3/29/23 and immediately initiated an investigation into the circumstances surrounding the child's death. It was learned the child had complex medical needs, impacting his quality of life. At the time of the child's death, he resided with his mother and the mother's partner. The mother was in foster care at the time of the child's death; however, had left her placement to reside with her partner on 12/9/22.

During the overnight hours of 3/29/23, after a feeding, the subject child was placed in his crib to sleep. The subject child continually rolled from his back to his stomach, so the mother got into the crib with the child to prevent him from rolling onto his stomach. The child fell asleep on his back and the mother's partner picked the mother up out of the child's crib and they returned to their bed. Around 10:30AM, the partner woke up to prepare for the child's next feeding, as the child was kept on a closely monitored feeding schedule. The partner saw the child was laying on his stomach and was face down. He rolled the child onto his back and noticed the child's lips were blue. He woke the mother and called 911. The mother began CPR. Law enforcement arrived, followed by emergency medical services. The child was pronounced dead at the home at 11:03AM and was not transported to the hospital.

The medical examiner was notified and performed an autopsy. Although the final autopsy results were pending at the time ACS closed their investigation, preliminary discussions with the medical examiner yielded no concerns for abuse or neglect. There were no signs of injury or trauma to the child. There were no abnormal findings other than his already known diagnosis of hydranencephaly, an abnormality of the brain he had been diagnosed with at birth. The medical examiner hypothesized that the death may have been related to complications from the various medical conditions compounded by the fact the child was not mobile and since he was found facing down, he may have asphyxiated. The child was noted to have global developmental delays and was unable to speak or walk. Pathology testing was completed but was anticipated to take awhile due to the amount of testing sent out. Preliminarily, the death was considered to be from natural causes.

ACS interviewed the mother and her partner. ACS gathered additional information regarding the child's medical diagnoses from his pediatrician. ACS spoke with the mother's foster care agency and learned the mother had been in foster care since 2017 with a permanency planning goal of Another Planned Permanent Living Arrangement. Although the mother was in foster care, the subject child was not, he was not a tracked child, and was not a part of any family court proceedings. On 12/9/22, the mother left her foster care placement and moved in with her partner in the partner's grandfather's apartment. The foster care agency continued to supervise the mother at this residence. The agency expressed

no concerns about the mother's care of the subject child.

The allegations against the mother and partner were unsubstantiated. Through collateral contacts, ACS found no preponderance of evidence to support that either the mother or her partner caused or contributed to the child's death.

The mother declined additional services offered by ACS in response to the fatality.

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:**
  - **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, therefore the safety assessment due at the time of determination was not required. The investigation was appropriately unfounded and closed and the foster care services case remained open due to the mother's placement status.

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 24-hour Fatality Report was completed late. There were missed opportunities to gather information from the partner's grandfather and to ask the mother about the child's biological father.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt

	of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour Fatality Report was completed untimely. The Report was approved in CONNECTIONS on 4/28/23, 29 days late. The Report contained the partner's interview, not otherwise recorded in the record.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The grandfather of the partner was not interviewed, although he resided in the home. The mother was not asked about the child's father.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/29/2023 **Time of Death:** 11:03 AM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 10:57 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	Male	3 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	25 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their response with law enforcement, notified the DA of the fatality, contacted the mother's foster care agency, and learned of the subject child's complex medical needs. There were no surviving siblings. Neither the mother nor her partner had CPS history as adults.

ACS learned the mother experienced a stroke while pregnant which caused the subject child to be born with a plethora of medical conditions and developmental delays. He was diagnosed with hydranencephaly, which meant he was born with almost no brain tissue and a buildup of fluid in the brain. He was functionally quadriplegic, unable to walk or do anything for himself. Additionally, he was diagnosed with dysautonomia, which affected his breathing and ability to regulate body temperature. He was fed primarily through a G-Tube. Furthermore, he suffered from a seizure disorder and cortical blindness, so he only saw figures and spots of light. He was followed by a pediatric complex care program, who described the mother as a "model mother." The pediatrician stated the mother did any and everything that was expected of her. The partner also played a role in the child's caretaking, and they had a schedule for who did what and when for the child. The pediatrician confirmed the partner's grandfather also cared for the child but did not feed the child. In February 2023, the mother contacted the pediatrician with concerns for the child's breathing. The child appeared well but his blood pressure began rising and he was admitted to the ER from the pediatrician's office until 3/23/23. The child suffered from excess secretions in his mouth. The pediatrician last saw the child on 3/28/23 for a follow-up appointment and he was doing well. The pediatrician confirmed the subject child was not expected to live long; however, the mother did everything in her power to ensure he lived as long as he could.

ACS interviewed the mother and partner. Around 11:00PM the night before his death, the mother was getting the child's food and medications ready. Sometime after his feeding, the child was placed in his crib. The mother said the child kept rolling over onto his stomach, suffocating himself, so the mother kept having to roll him over onto his back. Eventually, the mother got into the crib with the child to ensure he did not roll over onto his stomach. When the child fell asleep, he was on his back, and the partner picked the mother up out of the crib. The mother expressed the child's breathing was irregular that night and she felt he was prematurely discharged from the hospital. The partner was the first to wake up the morning of 3/29/23, around 10:30AM. He was waiting until 11:30AM to feed the child; however, noticed the child was "too quiet" and found the child laying on his stomach, face down. He rolled the child onto his back and the child's lips were blue. The partner woke the mother. The mother, trained in CPR, took the child out of crib, put him on the floor, and started CPR. The child was not responding, and she told the partner to call 911. The mother met first responders in the hallway. The child was pronounced dead at the scene and not transported to a hospital.

Law enforcement investigated and there were no arrests made as a result of the fatality. Law enforcement planned to close their case, citing the child died due to natural causes and they were just awaiting receipt of the death certificate.

The investigation was unfounded and closed.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063848 - Deceased Child, Male, 3 Yrs	063849 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
063848 - Deceased Child, Male, 3 Yrs	063850 - Mother's Partner, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
063848 - Deceased Child, Male, 3 Yrs	063849 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
063848 - Deceased Child, Male, 3 Yrs	063850 - Mother's Partner, Male, 25 Year(s)	Inadequate Guardianship	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:
The source was contacted on multiple occasions; however, successful contact was not made. The partner's grandfather, who reportedly resided in the home was not interviewed.

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:
Foster care services continued to be provided to the mother as she worked toward her goal of living independently.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
In response to the fatality, the mother was offered therapy services, a support group for loss, and bereavement counseling, which she declined. The mother continued to receive case management services through her foster care placement agency. The record did not reflect if the mother's partner was offered any 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? Yes

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