Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-039

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

Issue Date: Oct 03, 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 <u>**only**</u> 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:** New York | **Date of Death:** 04/13/2023
Age: 2 month(s) | **Gender:** Male | **Initial Date OCFS Notified:** 04/13/2023

Presenting Information

On 4/13/2023, the New York City Administration for Children's Services (ACS) received an SCR report alleging the death of the 2-month-old subject child which occurred that day. A family friend had found the subject child unresponsive in his crib and the maternal uncle started CPR while the mother contacted 911. Law enforcement and emergency medical services responded to the home, took over resuscitative efforts, and transported the subject child to the hospital. Life saving measures continued at the hospital; however, the subject child was pronounced deceased at 6:09 AM.

Executive Summary

This report concerns the death of the 2-month-old subject child which occurred on 4/13/2023. At the time of his death, the subject child resided with his mother, maternal grandmother, maternal uncle, and 13-year-old maternal aunt. ACS documented efforts to identify the biological father of the subject child; however, the mother declined to provide any information. The 13-year-old maternal aunt was assessed to be safe in the care of the maternal grandmother.

On 4/12/2023, the mother fed the subject child about 4oz of formula about every 3 hours, including at 11:00 PM, after which the mother placed the subject child to sleep in his portable crib and went to sleep herself in the same room. The mother placed the subject child to sleep on his right side with a blanket and pillow. The mother woke and fed the subject child around 3:00 AM, again placing the child back to sleep on his right side with a blanket and pillow. Around 5:00 AM, the family friend checked on the mother and subject child and found the subject child was facedown in the portable crib. The family friend woke the mother and instructed her to contact 911 before he went to wake the maternal uncle for assistance. The maternal uncle was a paramedic and began to perform CPR on the subject child.

Emergency medical services and law enforcement arrived at the home and took over resuscitative measures before transporting the subject child to the hospital. First responders noted the subject child was observed to be blue in color and not breathing upon their arrival and reported the subject child was observed to be free of suspicious marks, bruises, or injuries. Law enforcement noted they observed a pillow, milk bottle, two water bottles, and a blanket in the portable crib upon their arrival.

Hospital staff reported the subject child arrived around 5:50 AM in rigor mortis and cardiac arrest. Medical staff performed CPR; however, the subject child could not be intubated as his jaw had already set. The subject child was pronounced deceased at 6:09 AM. Hospital staff reported no concerns or suspicions of abuse or trauma to the subject child.

An autopsy was conducted on 4/14/2023; however, the final autopsy report and death certificate were not yet available at the time the CPS investigation was closed. The medical examiner reported to ACS that the cause and manner of death remained pending though the initial autopsy did not uncover signs of abuse. Law enforcement reported they learned from the medical examiner that the death may have been the result of accidental asphyxiation as the subject child was found facedown in an unsafe sleep environment. Law enforcement reported there were no findings of criminality related to the death of the subject child; however, their investigation remained ongoing pending the final autopsy report.

The allegation of Inadequate Guardianship was substantiated against the mother. ACS found that the mother routinely placed the subject child to sleep on his side with blankets over and under him, despite being educated on safe sleep

practices by the subject child's pediatrician and the maternal grandmother. The allegation of DOA/Fatality was unsubstantiated against the mother as there was not a preponderance of evidence that the unsafe sleep environment was the direct cause of the death. The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the maternal uncle and the family friend as they were deemed to not be persons legally responsible for the subject child and both denied knowledge of the mother utilizing unsafe sleep practices.

Fatality related services were offered to the family on multiple occasions during the investigation and ensuing Family Services Stage; however, the family declined to engaged with the services.

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

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:

ACS conducted an investigation that met all regulatory guidelines. Interviews with subjects and family members were conducted or attempted as required. Collateral sources were contacted as appropriate and records were gathered and documented per regulation. The determination was made in accordance of the information gathered and appropriate services were offered to the family.

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: 04/13/2023 **Time of Death:** 06:09 AM

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

County where fatality incident occurred: New York
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:

- [x] 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	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Other Child - Maternal Aunt	No Role	Female	13 Year(s)
Other Household 1	Other Adult - Family Friend	Alleged Perpetrator	Male	50 Year(s)

LDSS Response

Upon receipt of the SCR report on 4/13/2023, ACS initiated a timely investigation, assessed the safety of the maternal aunt, coordinated with law enforcement, interviewed family members, and gathered information from appropriate collateral sources.

The mother was interviewed alone at the family's home. The mother reported she fed the subject child every 3 hours as usual throughout the day and evening of 4/12/2023. The mother fed the subject child around 11:00 PM and placed him to sleep in his portable crib, on his side, with a blanket and pillow. The mother stated she woke around 5:00 AM when a family friend found the subject child facedown in the crib and not breathing. The mother could not recall specific events, such as who called 911 or when EMS arrived at the home as things were very hectic. The mother denied the subject child was sick in the days leading up to the death. The mother stated she routinely placed the subject child to sleep on his right side due to concerns that he could vomit or choke while sleeping. The mother also reported she had disclosed this to the subject child's pediatrician a few weeks prior to the death and the pediatrician was upset with her for doing so and

instructed her to only ever place the subject child to sleep on his back with no objects in the crib. The mother stated she continued to place the subject child to sleep on his side due to her concerns he could choke.

The family friend was interviewed alone and reported he visited the family regularly to spend time with the family and the subject child. The family friend stated he stayed at the home overnight on 4/12/2023 and last observed the subject child around 11:00 PM when the mother was feeding him a bottle and the subject child appeared well at that time. The family friend reported he woke around 5:00 AM on 4/13/2023 and checked on the mother and subject child before leaving for work. When he entered the mother's bedroom, he noticed the subject child was facedown in the portable crib. The family friend turned the subject child over and noticed he was not breathing. He woke the mother and the maternal uncle who contacted 911 and began to perform CPR, respectively. The family friend stated he had only ever observed the subject child sleeping on his back and was unaware that the mother would place the child to sleep on his side.

ACS documented repeated attempts to contact and interview the maternal uncle; however, the maternal uncle did not respond or make himself available to ACS at any time.

The maternal grandmother reported she had observed the mother to place the subject child on his side to sleep on a few occasions and had educated the mother regarding safe sleep. The grandmother stated she believed the mother had since followed safe sleep guidelines and stated she was unaware the mother continued to place the subject child to sleep on his side overnight.

The maternal aunt was interviewed and assessed to be safe in the care of the maternal grandmother. The maternal aunt did not have specific knowledge of what occurred the morning of 4/13/2023 and stated she did not have specific concerns for the subject child.

Through contact with hospital staff and the subject child's pediatrician, ACS learned the subject child was born 2 months premature and remained hospitalized for about 3 weeks before being discharged home to the mother. The subject child was seen at the hospital on 3/31/2023 for a hernia and on 4/3/2023 for constipation. The child was diagnosed and treated on the day of both visits and discharged home. Neither of those medical issues were believed to have contributed to the subject child's death. The subject child's pediatrician stated the mother brought the subject child for all routine appointments and there were no specific concerns for the subject child's health.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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
064798 - Deceased Child, Male,	064799 - Mother, Female, 19 Year(s)	Inadequate	Substantiated

2 Mons		Guardianship	
064798 - Deceased Child, Male, 2 Mons	064799 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
064798 - Deceased Child, Male, 2 Mons	064801 - Aunt/Uncle, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
064798 - Deceased Child, Male, 2 Mons	064801 - Aunt/Uncle, Male, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
064798 - Deceased Child, Male, 2 Mons	064803 - Other Adult - Family Friend, Male, 50 Year(s)	DOA / Fatality	Unsubstantiated
064798 - Deceased Child, Male, 2 Mons	064803 - Other Adult - Family Friend, Male, 50 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:

ACS documented multiple efforts made to contact and interview the subject maternal uncle; however, the uncle did not respond to any attempts at contact or make himself available to ACS at any time.

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
A Family Services Stage was opened to facilitate services referrals; however, the family declined services.

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? No
Explain:
ACS made referrals for services; however, the services were declined by the family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS made referrals for services; however, the services were declined by the family.

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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used prescription drugs
- ☐ Used marijuana
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ With fetal alcohol effects or syndrome
- ☐ Exhibiting withdrawal symptoms
- ☒ 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)
09/11/2022	Other Child - Maternal Aunt, Female, 12 Years	Aunt/Uncle, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report alleged the maternal uncle brandished an axe and physically assaulted another individual in the presence of the then 12-year-old maternal aunt.

Report Determination: Unfounded | **Date of Determination:** 11/10/2022

Basis for Determination:
ACS found that the maternal uncle had taken the maternal aunt on a short trip to purchase gasoline and engaged, in self-defense, in a physical dispute with other customers while the maternal aunt was inside the vehicle. The maternal aunt was unaware of the altercation and was picked up by another relative while the maternal uncle was arrested. The maternal uncle was charged with harassment and menacing and the court case remained ongoing at the time the CPS investigation was closed. The allegations were unsubstantiated as ACS found no evidence that the maternal aunt was aware of or was affected by the altercation and her needs did not go unmet during the time the maternal uncle was arrested.

OCFS Review Results:
ACS initiated a timely investigation and assessed for the safety of the maternal aunt immediately upon receipt of the SCR report. All family members were interviewed and the safety of the home was assessed. Collateral sources were contacted as appropriate and records were gathered and documented timely. Casework met all regulatory guidelines.

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

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

A 3/28/2020 SCR report alleged the maternal grandmother and maternal uncle were physically violent towards an unrelated child. The allegations of IG, SWDS, LABW, and IINJ were unsubstantiated.

SCR reports dated 10/12/2018, 6/8/2015, and 1/27/2014 contained allegations of IG and LABW against the maternal grandmother regarding the maternal aunt and children unrelated to this report. Those allegations were unsubstantiated.

A 9/14/2014 SCR report alleged IG and LABW against the maternal grandmother regarding the maternal aunt and 2 children unrelated to this report. The allegation of IG only was substantiated regarding the unrelated children and all allegations regarding the maternal aunt were unsubstantiated.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A Family Services Stage was opened on 7/17/2006 to provide services to the family regarding an incident concerning a child unrelated to the fatality investigation who is now an adult. The maternal aunt was added to the case composition on 2/4/2011 and services were provided to the maternal aunt and multiple other children as well as the maternal grandmother. The services included educational services, housing assistance, early intervention services, legal services, child care services, and mentoring services. The FSS was closed on 7/30/2014.

A voluntary services case was opened on 7/14/2010 to provide services to the maternal grandmother, maternal grandfather, the maternal aunt, and 3 other children. Services included medical, mental health, domestic violence, batterer's counseling, and family support services. The family did not engage and the services case was closed 9/1/2010.

A Family Services Stage was opened on 8/26/2015 to provide services to the maternal grandmother, maternal aunt, and 3 other children. Services included medical, mental health, and shelter. The services case was closed on 9/18/2017.

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