Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-040

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

Issue Date: Aug 10, 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
Age: 9 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 04/16/2023
Initial Date OCFS Notified: 04/16/2023

Presenting Information

Two SCR reports were received on 4/16/23, which alleged that on 4/15/23, at 9:00PM, the mother put the subject child in his crib for the night. The morning of 4/16/23, around 5:30AM, the father checked on the child and the child was fine at that time. The mother then woke around 2:30PM and checked on the child in his crib. The mother found the child unresponsive. The mother called 911 and the father attempted CPR. Emergency medical services arrived at the home; however, the child was already deceased. The child was an otherwise healthy child, and the parents did not have an explanation for his death. Additionally, the child had a healing wound on his chin, and an abrasion on his face which the parents were unable to explain.

Executive Summary

This report concerns the death of the 9-month-old subject child. The Administration for Children's Services (ACS) received two SCR reports regarding the child's death on 4/16/23. At the time of the child's death, he resided with his mother and father.

On the evening of 4/15/23, the mother fed the child a bottle around 9:00PM, changed his diaper, and put him down for bed in his crib. The father left the house at that time and the mother went to bed around 11:00PM. The father returned home early the morning of 4/16/23 and checked on the child in his crib. The father repositioned the child from his stomach to his side, so he was lying on his left side. The child did not cry, make noise, or wake at that time. The mother was asleep at that time and the father then went to sleep as well. The mother woke up around 2:00PM. The mother checked on the child, and he was not moving or breathing. It was not noted if any items were in the crib with the child, or in what position he was found. She picked the child up and brought him to her bed. The father was awoken at that time by the mother. The mother called 911 at 2:52PM and the dispatcher instructed the father on how to perform CPR until emergency medical services arrived at the home. Emergency medical services found the child pulseless, apneic, and with signs of obvious death. Rigor mortis was noted throughout his arms, legs, and chin. The child was pronounced deceased in the home at 3:00PM.

The medical examiner was notified and performed an autopsy. The cause and manner of death were pending at the time the CPS investigation was closed. The child had marks on his chin and cheek which the parents provided different explanations for. The medical examiner was still examining and awaiting results from histology and did not offer input on the cause of the marks. Discoloration noted on the child's body was explained by lividity. While asked about the origin of specific marks to the child's body, the medical examiner was not asked about the overall impressions of the child's physical appearance. The medical legal investigator noted the child was "too clean" in that he appeared washed, and there were no signs of trauma to the body. Law enforcement's investigation remained ongoing pending autopsy results.

ACS unsubstantiated the allegations in the report; however, there was insufficient information gathered to determine the allegation of Inadequate Guardianship. The parents described a rigid, four-times-a-day feeding schedule that consisted of mixing a combination of Enfamil formula, Gerber infant cereal, chocolate-flavored Nestle Nesquik, and Beech-Nut Stage 2 fruit into a bottle. This practice was not discussed with the medical examiner or pediatrician. The mother reported a well-child visit occurred 4/11/23; however, this was not confirmed. The information gathered through interviews with the parents implied the child last received a bottle around 9:00-10:00PM on the evening of 4/15/23 and had not received another bottle prior to being found deceased around 2:00PM on 4/16/23. Additionally, the father described a routine in which the child was in his Pack 'n Play or crib most of the day and night. Collateral contacts to fully assess any physical

or developmental harm to the child, because of the feeding and sleep schedule, were not completed prior to a determination being made.

The parents were offered and declined bereavement service referrals. Burial assistance was offered but not accepted. The mother was pregnant and was provided a community resource pamphlet on preventive services related to family support, education, job training, and public assistance, as well as a food resource list and legal support. Despite the father's history of having two previous children removed at infancy due to concerns of being unable to provide adequate supervision or meet a child's basic needs, the parents were not referred to services to help them prepare for the impending arrival of another child.

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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
Safety Assessments were not required as there were no surviving siblings. There were missed opportunities to communicate with relevant collaterals to gather sufficient information to determine the Inadequate Guardianship allegations.

Was the decision to close the case appropriate?	Yes
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:
Although the case was closed prior to relevant collateral contacts being made, there were no surviving children or ongoing services being provided that would require the case to remain open.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	The allegations of IG were pre-determined. Collateral contact with the pediatrician could have provided further information; however, the case was closed prior to successful contact. The ME was not asked for an overall physical assessment of the SC.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment.
Issue:	Failure to provide safe sleep education/information
Summary:	A progress note noted that safe sleep information was not provided as there was no child under the age of 1 in the home; however, it was known the mother was pregnant at that time.
Legal Reference:	13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:	ACS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/16/2023 **Time of Death:** 03:00 PM

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: 02:52 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	9 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)

LDSS Response

ACS initiated their investigation within 24 hours and coordinated their efforts with LE. ACS contacted the sources of the reports, completed a CPS history check regarding the family, and informed the DA of the fatality. There were no surviving siblings in the home; however, the father had two CHN who resided with a relative via KinGAP. The father had no contact with those CHN. An initial home visit was conducted the date the reports were received.

ACS interviewed the parents separately and their recollection of events differed at times. The mother said the child woke up at 6:00AM the morning of 4/15/23, although she remained asleep until 10:00AM and reported the father tended to the child. The mother engaged in a virtual therapy session from 10:30-11:00AM, then went back to sleep, as she said the father and child were also sleeping. The mother woke again at an unknown time in the afternoon. The mother recalled feeding the child a bottle at 9:00PM, changing the child's diaper, and placing the child back down to sleep. The mother then went to sleep around 11:00PM. The father left the apartment to visit friends at 9:00PM and did not return until 5:00AM the next morning (4/16/23). On 4/16/23, the mother did not wake up until about 2:00PM in the afternoon, at which point she checked on the child in his crib and the child was not breathing. She picked him up out of the crib, woke the father, and called 911. The mother handed the phone to the father, who performed CPR as instructed by the dispatcher until EMS arrived.

The father said the child was on a "schedule," which they had been following since March 2023. The child received four 8oz bottles a day, containing the formula, Nesquik, cereal, and fruit mixture. This feeding schedule was developed by the parents, and it was unknown if the pediatrician was aware of the schedule and contents of the child's bottle. The father reported various waking times for the child; 4:30AM, 5:00AM, or 8:00AM. The child was fed and changed upon waking, then put down until his bath at 6:30PM. ACS attempted to elicit more detail from the father; however, he maintained that was the child's routine and he did not wake to play, cry, or be fed between being placed down in the morning and being given a bath at 6:30PM. The evening of 4/15/23, the child received his last bottle around 9:00 or 10:00PM and the father left the home. On 4/16/23, at 5:00AM, the father checked on the child upon returning home, and observed he had turned around in the crib so that his head was positioned where his feet usually were, and he was on his stomach. The father repositioned him to his left side, then the father returned to his bed and was next awakened by the mother's screams, around 2:00PM. Regarding the mark on the child's chin, the mother reported it was from drool and rubbing on the netting of the Pack 'n Play, and the father said it was from the bottles being too warm. The mother said the mark on the child's left cheek was a self-inflicted scratch and the father said it was a pimple. The marks were treated with bacitracin.

ACS obtained releases of information for the mother's mental health provider and the child's pediatrician. ACS learned the mother had mental health diagnoses prior to the mother revoking her release. The mother reported the child was diagnosed with microcephalus, ectopic dermatitis, and jaundice; however, successful contact with the pediatrician was not made.

As the investigation continued, the parents became uncooperative with ACS. The medical legal investigator would not share their final report with ACS, as they sent their report to the ME. The ME's report remained pending. An attempt was documented 5/3/23 to obtain the child's medical records. It was learned on 6/12/23 that the release had not been received by the child's medical provider, and the case was then determined on 6/13/23 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 region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064252 - Deceased Child, Male, 9 Mons	064254 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
064252 - Deceased Child, Male, 9 Mons	064254 - Father, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
064252 - Deceased Child, Male, 9 Mons	064254 - Father, Male, 35 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
064252 - Deceased Child, Male, 9 Mons	064253 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
064252 - Deceased Child, Male, 9 Mons	064253 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
064252 - Deceased Child, Male, 9 Mons	064253 - Mother, Female, 30 Year(s)	Lacerations / Bruises / Welts	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 CPS investigation was determined and closed prior to receiving requested medical records from the child's pediatrician. ACS was provided with the child's Dr.'s name on 4/17/23; however, the record did not reflect attempts to contact the Dr.

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:
The father had a history of having children removed at infancy, and it was known the family was expecting another child; however, service referrals specific to parenting skills were not offered. Historical records reflected the father had an intellectual disability and a pattern of domestic violence; however, service needs around these issues were not fully explored.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were provided bereavement and grief counseling resources. The mother indicated she would utilize her therapist, who she was already working with. It was unknown if the father engaged in 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

The father had history with ACS regarding two additional children.

In 2/2015, the allegation of Inadequate Guardianship was substantiated against the father regarding his then 1-day-old female child. The child was removed as neither the father nor the child's mother were able to provide adequate supervision or meet the child's basic needs. The record noted the father was diagnosed with an intellectual disability.

In 4/2016, the allegation of Inadequate Guardianship was substantiated against the father regarding his then 1-day-old

male child. That child's sibling, previously removed in 2015, remained in foster care. The record noted the father and that child's mother had diagnoses of intellectual disabilities. It was determined neither parent could provide adequate supervision for the 1-day-old without the intervention of court ordered services, which included preventive and home making services. An 11/2016 SCR report resulted in that child's removal. The allegation of Inadequate Guardianship was unsubstantiated against the father because at that time there was an Order of Protection and the father only had supervised visitation, which he was not utilizing. The father was not a caretaker to the child at the time that report was received.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Foster Care Placement History

The father's two additional children were removed shortly after their birth, in 2015 and 2016. The record reflected the reason for the placement of the father's two other children was due to the father and those children's mother having untreated mental health and domestic violence in the household. It was noted the father had cognitive delays which impacted his ability to care for the children. The father's service plan included engaging in mental health treatment, specifically dyadic therapy. The father had supervised visitation. The father stopped visiting with the children in 11/2018, made minimal to no progress in service plan goals, and permanency for both children was ultimately obtained through KinGAP in 4/2019.

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