Child Fatality Report

Report Identification Number: NY-23-044

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

Issue Date: Oct 13, 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:** Bronx **Date of Death:** 05/08/2023
Age: 2 year(s) **Gender:** Male **Initial Date OCFS Notified:** 05/08/2023

Presenting Information

An SCR report alleged that on 5/8/23, the mother and father were home with the 2-year-old subject child and two siblings. At 12:15 AM, the mother fed the child and then laid him to sleep in his crib. At 2:15 AM, the mother got up to check on the child. The mother observed the child was not breathing and was unresponsive. The mother woke the father who contacted 911. Emergency medical services arrived at the home and performed cardiopulmonary resuscitation. The child was pronounced deceased and transported to the hospital. The mother and father were unable to provide an explanation for the death of the child.

Executive Summary

This fatality report is regarding the death of a 2-year-old male child that occurred on 5/8/23. The SCR report alleged DOA/Fatality and Inadequate Guardianship against the mother and father regarding the subject child. At the time of his death, the child resided with his mother, father, great-uncle, and two siblings, ages 1 and 4 years. The mother had guardianship of her two cousins, ages 16 and 17 years, and they also resided in the home. Following the death, a safety plan was implemented in which the grandfather supervised the surviving children in the parents' care. After additional information was gathered, the children were determined to be safe and the plan ended.

The Administration for Children's Services (ACS) coordinated investigative efforts with law enforcement. It was learned that on 5/8/23 at 12:15 AM, the mother gave the child cereal and liquid medication and placed him to sleep in his crib. At 2:15 AM, the mother woke up and realized she forgot to provide the child with his pill medication. The mother observed that the child was not responding so she woke the father. The father performed cardiopulmonary resuscitation and they called 911. The father ran the child to the lobby. First responders arrived and transported the father and child to the hospital where the child was pronounced deceased.

The family declined an autopsy due to their religious practices. Upon an external examination, the findings were undetermined. There was no suspicion of neglect or child abuse and no suspicion of criminology; therefore, the Medical Examiner was unable to override the family's wishes regarding the autopsy. A healed leg fracture was discovered during the exam. The injury was reported to have occurred during the child's birth and had no relation to the death. The child also had a fever of 104 degrees. Law enforcement investigated the fatality and there were no criminal charges when the CPS investigation was closed.

Upon receipt of the information regarding the child's healed leg fracture, ACS completed an immediate home visit and implemented a safety plan. The maternal grandfather agreed to remain in the home and provide supervision of the children with the parents. A safety conference was held and the family was willing to accept preventive services. A neglect petition was not filed; however, ACS requested a subpoena to obtain medical records for the child. The judge issued the subpoena and medical records since the child's birth were obtained and reviewed. The medical records did not have any information regarding the child sustaining the leg injury during his birth and the mother was not sure how the child obtained the injury. Law enforcement, the district attorney's office, and the Medical Examiner expressed no concern for abuse or maltreatment. Given this information, the safety plan was terminated.

The allegations of DOA/Fatality and Inadequate Guardianship were unsubstantiated against the mother and father regarding the subject child. ACS determined during the investigation that there was no evidence to support that the mother or father were responsible for the child's death. The subject child was born medically fragile with many health

complications and the mother and father put forth great efforts to provide for the child's medical needs.

The mother agreed to preventive services through a community-based agency. The agency's planning for the family included parenting classes, bereavement and mental health counseling, funeral assistance, and overall assistance with family needs. ACS provided the family with sleeping provisions for the children, assisted in enrolling the 1-year-old in early intervention, and obtained a special education evaluation for the 4-year-old sibling. Another agency provided the family with homemaking services. The CPS investigation was unfounded and closed on 6/9/2023.

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:**
  - **Approved Initial Safety Assessment?** — No
  - **Safety assessment due at the time of determination?** — No
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** — Yes

Explain:

The safety assessments did not encompass all of the children in the home, as the 16 and 17-year-old cousins were not interviewed.

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** — Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** — Yes

Explain:

The determination was appropriate given the information obtained during the investigation.

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 family was engaged with preventive services at the closure of the CPS investigation.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The record reflected that the household consisted of the mother, father, siblings, child, and the mother's brother and two cousins. It was not documented that the 16 and 17-year-old cousins and the adult uncle were interviewed.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/08/2023 **Time of Death:** 02:50 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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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	Aunt/Uncle	No Role	Male	26 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	17 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

LDSS Response

Upon receipt of the SCR report on 5/8/23, ACS coordinated efforts with law enforcement, sent notification to the Medical Examiner, interviewed the family, gathered information from medical collaterals, and assessed the safety of the surviving children.

It was learned through a review of medical records and interviews with the parents that the child experienced complications during his birth that resulted in his hospitalization for several months. After his discharge from the hospital, the child was in receipt of weekly early intervention services and neurological monitoring. The child suffered from developmental issues with an inability to control his limbs and other challenges associated with his diagnosis. The child received support for eye coordination, standing ability, neck stability, rolling over, and crawling, all of which the mother stated were not achieved due to the severity of the child's medical issues. The child had a daily medication regime and required tube feeding. Hospital records indicated that any medical directives issued to the parents were followed, which ACS reported assisted them in ruling out any medical neglect of the child. It did not appear the child had a pediatrician, but the mother would utilize the emergency room for support, in addition to the services in place.

ACS interviewed the mother and father at their home regarding the incident. On the evening of 5/7/23, the father was at work and the mother was home with the child. The father returned home around 8:20 PM and the child was already asleep. At approximately 10:00 PM, the father put the siblings to sleep and then went to sleep himself. On 5/8/23 at 12:15 AM, the mother fed the child cereal and gave him his liquid medication. Two hours later, the mother woke and remembered she had forgotten to give the child his pill medication. When the mother went to administer the medication, the child was not responding. The father was woken up by the mother telling him the child was not moving. The father told the mother to call 911 and the father performed cardiopulmonary resuscitation. The father believed the child was already deceased. The father was met by first responders in the lobby of their building. Life-saving efforts were initiated and the father and child were transported to the hospital. The child was pronounced deceased at the hospital and the father informed the mother of his death. The parents denied any substance misuse, domestic violence, criminal activity, or any other child welfare concerns.

ACS attempted to interview the 4-year-old sibling; however, he was minimally cooperative during the interview. The 1-year-old sibling was not interviewed due to his age, but his safety was otherwise assessed. The record reflected the 17-year-old cousin was seen during the investigation but was not interviewed. The record reflected the 16-year-old cousin was not added to the household composition, his safety was not assessed, and he was not interviewed. ACS opened a prevention case following the fatality case in which the 16-year-old was seen at the home after the conclusion of the CPS investigation. An interview with the uncle was not documented during the investigation.

ACS requested medical evaluations of the 1 and 4-year-old siblings. The siblings were observed with no visible marks or bruises. The 1-year-old had a cold and the mother reported she was providing medication. The 4-year-old had no medical issues. There were no documented concerns for the 16 and 17-year-old cousins.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: Undetermined if injury or medical cause
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
064848 - Deceased Child, Male, 2 Yrs	064849 - Mother, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
064848 - Deceased Child, Male, 2 Yrs	064849 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
064848 - Deceased Child, Male, 2 Yrs	064850 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated
064848 - Deceased Child, Male, 2 Yrs	064850 - Father, Male, 38 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 record did not reflect the uncle and two cousins were interviewed.

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?	☒	☐	☐	☐
Explain: The 16-year-old sibling was not assessed during the investigation. The progress notes did not reflect he was interviewed or present during any casework contacts.				
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?	☒	☐	☐	☐
Explain: A safety plan was implemented upon receipt of information regarding the child having a healed leg fracture. The maternal grandfather supervised contact between the surviving children and parents. Once additional information was discovered regarding the injury, the safety plan concluded.				

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	☒	☐	☐	☐
Explain: The risk assessment was adequate for the siblings but was not adequate in assessing risk regarding the cousins.				

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?	☐	☒	☐	☐

Explain as necessary:
The surviving children were not removed as a result of the information discovered 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: Sleeping provisions

Additional information, if necessary:
ACS provided a Pack N' Play and beds for the surviving children. The family engaged in preventive services,

homemaking services, and parenting classes. ACS assisted the family in obtaining early intervention and special education services for the siblings. The family declined bereavement and it was unknown if they accepted the assistance offered for the funeral.

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

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 mother of the cousins had unfounded CPS investigations in 2013 and 2016, alleging Inadequate Guardianship regarding the 16 and 17-year-old cousins.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

Between 2014 and 2021, there was an open services case that was initiated to provide support to the family due to medical concerns for the cousins' mother. The cousins were placed in foster care while their mother had surgery. The mother of the subject child began assisting the family, and on 5/24/19, the subject child's mother was granted guardianship of the cousins after their mother died. The subject child's mother was meeting the needs of the cousins and there were no safety concerns. The case was kept open temporarily for housing assistance and was subsequently closed.

Between 2011 and 2013, there was an open services case regarding the 17yo cousin that was initiated after there were reported concerns for the cousin's skin condition. During the services case, the cousin's mother became sick and the cousins needed to be placed in foster care. The cousins were returned home with services in place to assist their mother. The goals were met and there were no safety concerns. The family was referred to community-based services and the case was closed.

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