Child Fatality Report

Report Identification Number: NY-23-074

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

Issue Date: Jan 05, 2024

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 08/01/2023
Initial Date OCFS Notified: 08/01/2023

Presenting Information

Two SCR reports were received that alleged on 7/31/23, the mother fed the 1-month-old male subject child and placed him in his bassinet without burping him. The mother went to sleep and awoke about two hours later. When the mother woke up, she went to check on the child and observed foam coming from the child's nose and mouth. The mother called the child's father and then called 911. First responders arrived at the home and transported the child to the hospital. Hospital staff took over life-saving measures; however, the child was later pronounced deceased at 10:31PM. The mother was the caretaker at the time and had no explanation for the child's death. The father had an unknown role.

Executive Summary

New York City Administration for Children's Services (ACS) received two SCR reports regarding the death of the 1-month-old male subject child. The reports alleged DOA/Fatality and Inadequate Guardianship against the mother regarding the child. At the time of the death, the child resided with his mother, father, and paternal uncle. There were no surviving siblings.

OCDSS learned on 7/31/23, at about 9:00AM the mother fed the child a bottle of formula and put him down for a nap in a bassinet in his room. The mother went to go lay down in another room and fell asleep. Sometime around 11:45AM, the mother heard the child crying. The mother went to check on the child and found him foaming at the mouth and unable to breathe. The mother did not speak English and immediately called the father at work, who then called the paternal uncle, and the paternal uncle called 911. First responders arrived at the home, began resuscitative measures, and transported the child to the hospital. The child was transferred to another hospital for a higher level of care and upon arrival the child was in cardiac arrest. Hospital staff was able to resuscitate the child and obtain a pulse; however, the child later passed away at the hospital on 7/31/23 at 10:26PM.

ACS spoke with hospital staff who reported the child died as a result of cardiac arrest and there was no trauma observed on the child's body. ACS was made aware by hospital staff the parents requested an autopsy not be performed due to religious beliefs; however, the record reflected the child's body was sent to the medical examiner on 8/1/23. The record was unclear if an autopsy or toxicology testing was performed on the child. ACS obtained the child's medical examiner number; however, the record did not reflect ACS asked the medical examiner's office about the child's death. The record did not reflect ACS spoke with the law enforcement regarding the child's death or if there was a criminal investigation regarding the death.

The record did not reflect the 24-hour Safety Assessment was completed for the fatality report. The 24-hour Fatality report was completed on time on 8/4/23; however, was approved late on 9/26/23. The 30-day Fatality report was completed late on 9/22/23 and approved late on 9/26/23. The record did not reflect the district attorney's office was notified regarding the death. ACS met with the parents and paternal uncle at the hospital and at a home visit on 8/1/23; however, the record did not show the father, or the paternal uncle were fully interviewed, and the mother was not asked any risk assessment questions. ACS missed opportunities to gather relevant casework and collateral contact information that could have potentially provided further information regarding the death of the child and the allegations in the report. The record did not reflect ACS spoke with collateral contacts such as the source of the initial report, first responders, hospital staff from the initial hospital the child was brought to, or the pediatrician. There was no casework activity from 8/11/23 through the close of the investigation, with the exception of two supervisory notes. The record did not reflect ACS appropriately investigated the circumstances surrounding the child's death.

ACS offered the family bereavement services and burial assistance and they declined. After the death of the child the parents returned to their home in another state. ACS unfounded the allegations of DOA/Fatality and Inadequate Guardianship against the mother citing there were no surviving children in the home and a lack of the preponderance of evidence. The CPS investigation was unfounded and closed on 9/26/23.

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?** 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?** Unable to determine - insufficient documentation.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
Casework activity was not commensurate with the casework circumstances. ACS missed opportunities to gather relevant casework and collateral contact information that could have potentially provided further information regarding the death of the child and the determination of the allegations.

Was the decision to close the case appropriate? Unknown

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:
Casework activity was not commensurate with the case circumstances. The 24 hour and 30-day fatality reports were completed and approved late, there was no 24 hour safety assessment completed. Relevant casework and collateral contacts were not completed.

Required Actions Related to the Fatality

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

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	A 30-day Fatality Report was not documented or approved in Connections within 30 days of receipt

	of the report. The 30-day Fatality report was completed late on 9/22/23 and not approved until 9/26/23. The 30-day report contained information that was not factual.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must document and approve a 30-day Fatality Report within 30 days 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:	Failure to utilize an approved MDT
Summary:	The record did not reflect the death was investigated by the approved ACS MDT team after the fatality report was made.
Legal Reference:	SSL 423(6); SSL 424 (5-a); 10-OCFS-LCM-09
Action:	CPS reports with allegations of sex abuse and cases that involve the death of a child, where an ACS has chosen to establish an OCFS approved multidisciplinary team (MDT), must be investigated by the MDT. In local districts where no MDT has been established, ACS must jointly investigate the above-named CPS cases with law enforcement.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The record did not reflect the father and paternal uncle were interviewed.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-hour safety assessment was not completed for the fatality report.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	A safety assessment will be documented and approved by a supervisor within 24 hours of a report if such report contains the allegation of DOA/Fatality, as required.
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:	A 24-hour Fatality Report was not documented or approved in Connections within 24 hours of receipt of the report alleging the death of a child as a result of abuse or maltreatment. The 24-hour Fatality report was completed on time on 8/4/23; however, was approved late on 9/26/23.
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:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	The case was pre-determined to the assessment of the allegations. The record did not reflect ACS gathered relevant casework or collateral information that could have potentially provided further information regarding the SC's death and the determination of the allegations in the report.
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, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/01/2023 **Time of Death:** 10:26 PM

Date of fatal incident, if different than date of death: 07/31/2023
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? 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	1 Month(s)
Deceased Child's Household	Father	No Role	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

ACS received two reports regarding the death of the SC. ACS began their investigation within 24 hours, completed a CPS history check for the family, and made a home visit. ACS used a translator to speak with the parents because the parents did not speak English. There were no surviving siblings.

The mother reported the SC was born premature at 28 weeks and was hospitalized for 1 month after his birth. The mother and father have a home in another state and the mother was staying with the paternal uncle because the SC was

hospitalized after birth. The mother said the SC was diagnosed with a virus called Cytomegalovirus (CMV) and was prescribed an oral medication that was last taken about 2 weeks prior to the SC's death. The SC was retested for the virus on 7/25/23, and the results were pending. ACS observed the SC's medication that was prescribed for CMV at the home visit on 8/1/23, and obtained releases for the pediatrician and other collaterals. The record reflected ACS observed a discharge paper from the SC's pediatrician appointment on 7/18/23.

ACS asked the parents about the events that led to the SC's death. The father stated he was at work and the mother was at the home alone with the SC. The mother was interviewed at the hospital, and she could not remember what time she gave the SC a bottle and placed him down for a nap and that she found the SC foaming from the mouth. ACS interviewed the mother again at the home visit and the mother reported at about 9:00AM, the mother fed the SC a bottle of formula. A short time later the mother put the SC on his back in the bassinet and the mother went to another room to take a nap. Around 11:45AM, the mother heard the SC crying. The mother went and checked on the SC and said the SC was vomiting and struggling to breathe. The mother did not know what to do and she called the father, the father called the paternal uncle, and the paternal uncle called 911. ACS did not interview the father. The paternal uncle was seen but not interviewed regarding any concerns for the mother's care of the SC.

ACS obtained releases to speak with collateral contacts; however, the record did not reflect ACS made attempts to speak with the SC's pediatrician, first responders, or hospital staff from the first hospital the SC was brought to. LE was at the hospital the night of the fatality and told ACS the case would be transferred to different department. The record did not reflect ACS made diligent efforts to speak with LE after the death of the SC or prior to case closure. ACS contacted the ME's office regarding the SC's ME number; however, did not ask any questions regarding the death. ACS offered bereavement services and burial assistance to the parents, and they declined. The paternal uncle was offered bereavement services, and he declined. The record was unclear as to the cause and manner of the SC's death. The record did not reflect ACS obtained information from relevant collateral contacts that may have provided relevant information in determining the allegations in the report. There were no surviving siblings and ACS unfound and closed the CPS investigation.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The record did not reflect the death was investigated by the approved ACS MDT team after the fatality report was made.

Was the fatality referred to an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066018 - Deceased Child, Male, 1 Month(s)	066019 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
066018 - Deceased Child, Male, 1 Month(s)	066019 - Mother, Female, 26 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Law Enforcement	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
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?	☐	☒	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☐	☒	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The record did not reflect ACS spoke with relevant collateral contacts regarding the child and the death. The paternal uncle was not interviewed although he resided in the home, and the father was seen twice and never 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:
ACS offered the parents bereavement counseling and burial assistance, and they declined.

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? N/A
Explain:
There were no surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS offered the family bereavement services and burial assistance, and the parents declined.

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

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