Report Identification Number: NY-23-081

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

Issue Date: Jan 22, 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		

Case Information

Report Type: Child Deceased	**Jurisdiction:** Kings	**Date of Death:** 08/29/2023
Age: 2 month(s)	**Gender:** Male	**Initial Date OCFS Notified:** 08/29/2023

Presenting Information

An SCR report alleged the mother fed the 2-month-old child and put him to bed at 12:00 AM on 08/29/23. The mother placed the child in a car seat that attached to a stroller. At 4:00 AM, the mother planned to feed the child but found him to be cold to the touch with blood under his nose. The mother called 911. EMS arrived, performed CPR for 35 minutes and transported the child to the hospital. The child was pronounced deceased at 5:28 AM. The cause of death was cardiac attest. The child did not have medical conditions that would have contributed to his death. A duplicate SCR report was received on the same day.

Executive Summary

This report concerns the death of the 2-month-old child that occurred on 08/29/23. Two reports were made to the SCR on the same day alleging the mother found the child unresponsive after placing him to sleep in a car seat. At the time of his death, the child resided with his mother, grandmother, adult aunt, 15-year-old aunt, and siblings aged 1, 2, 4, 6 and 11 years. The siblings and aunt were assessed to be safe in the care of the adults.

The Administration for Children's Services (ACS) coordinated investigative efforts with law enforcement upon receipt of the SCR reports. The outcome of the criminal investigation remained pending at the time this report was written. An autopsy was performed; however, the autopsy report was not yet available at the time this report was written. There were inconsistencies in the record as ACS documented the medical examiner reported the child's death was due to an upper respiratory infection and was accidental, an upper respiratory infection contributed to the death, as well as the child died of natural causes.

The mother reported putting the child to sleep in a car seat and later finding him unresponsive, cold, and stiff. The mother screamed, waking the adult aunt and maternal grandmother. The aunt performed CPR and called 911, as did the mother. EMS arrived and transported the child to the hospital where he was pronounced deceased. The father was not present when the mother discovered the child unresponsive; however, arrived to the home around the same time as the first responders. The adult aunt and maternal grandmother corroborated the mother's recollection of the incident.

The record reflected the mother was aware of safe sleeping recommendations; however, placed the child in a car seat to sleep as she did not have a crib or bassinet for the child. The mother stated she made attempts to obtain an appropriate sleeping space for the child at no cost to her but was unsuccessful.

ACS contacted appropriate collateral contacts and interviewed family members. ACS completed all required reports and Safety Assessments timely. The Safety Assessments were completed inaccurately as they included the child despite his death, and they reflected the surviving children were in immediate or impending danger; however, this was not reflected in the progress notes. The allegation of Inadequate Guardianship was substantiated against the parents. Although there was a fair preponderance of evidence to substantiate the allegation against the mother as she consistently placed the child in an unsafe sleeping environment, Inadequate Guardianship was inappropriately determined against the father as he was not present at the time of the fatal incident, nor did he place the child in the unsafe sleeping environment. Both parents were unsubstantiated for the allegation of DOA/Fatality. The Investigation Conclusion Narrative stated "there was no credible evidence" to support the allegation as the child died as a result of natural causes and the medical examiner did not find signs of abuse. The child had a respiratory infection at the time of his death. ACS added the allegation of Lack of Medical Care against the mother; however, the reasoning for this was not documented. The allegation was

unsubstantiated. The Investigation Conclusion Narrative reflected the father was unsubstantiated for Lack of Medical Care; however, the case record did not reflect the allegation was against him.

The family was offered bereavement services, which were accepted. The mother was offered a referral for Early Intervention regarding a sibling but declined. The investigation was closed on 10/27/23.

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:**
  - **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?** — No

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?** — No

Explain:
Casework activity was not commensurate with case circumstances as the Safety Assessments were completed inaccurately. The allegation of IG against the father was inappropriately determined.

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:
The decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	Safety Factors were selected that included the SC. Safety Factors chosen were not concerns during the current investigation and the record did not reflect the MGM's mental health diagnosis impacted her ability to care for the children.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.
Issue:	Appropriateness of allegation determination
Summary:	Inadequate Guardianship was inappropriately substantiated against the father. The father did not reside in the home nor was he in the home when the mother placed the child to sleep in the car seat.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the New York City Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/29/2023 **Time of Death:** 05:28 AM

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

County where fatality incident occurred: Kings
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	Aunt/Uncle	No Role	Female	26 Year(s)

Deceased Child's Household	Aunt/Uncle	No Role	Female	15 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	28 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	40 Year(s)

LDSS Response

On 08/29/23, ACS received the reports from the SCR. Within the first 24 hours of the death, ACS contacted the sources of the reports, notified the medical examiner and district attorney's offices of the death, coordinated with law enforcement, and documented a CPS history check.

On 08/29/23, a home visit was made, and the family was interviewed. The mother reported putting the child to sleep in a car seat around 12:30 AM on the same day. She did not have a crib for the child and was awaiting public assistance. The mother did not hear the child cry for his usual feeding and checked on him. She picked the child up and attempted to nurse him but noticed he would not latch. The mother turned on the light and noticed the child was cold, stiff and had a clenched fist. She screamed and the adult aunt and grandmother came into the room. Calls were made to 911 and CPR was performed at the instruction of the operator until first responders arrived and took over resuscitation efforts.

The father was present during the home visit and stated the mother called him after finding the child unresponsive and he immediately came to the residence. He did not have concerns for the care the mother provided to the children. The siblings were assessed as safe. They did not provide information regarding the fatal incident as they were either too young to speak or chose not to engage with ACS.

The adult aunt and grandmother were interviewed. They reported they woke to the mother screaming that the child was not breathing. The adult aunt attempted to find a pulse on the child but was unable. She performed CPR and called 911. The child was reported to have been fine the day prior to his death.

A hospital doctor reported he believed the child died as a result of natural causes and he did not find signs of abuse during the autopsy exam. The doctor believed the child had a respiratory infection and that there were "no signs of suffocation."

On 08/30/23, another home visit was made. The mother said that on the day prior to the death, the child fed normally but vomited during a feeding. She called the pediatrician's office to no avail, so she searched the internet for advice. She continued to monitor the child and had no further concerns. She reported feeding the child around 12:00 AM on 08/29/23, placed him in the car seat and he went to sleep. She checked on the child around 4:00 AM as he did not cry for his feeding, and she discovered him to be unresponsive at that time. The mother was distraught and did not provide further information. The minor aunt was assessed and did not provide information regarding the fatal incident.

The record reflected the medical examiner reported concerns for the child sleeping in a car seat, and that the child had a respiratory infection. The results of the final autopsy remained pending at the time this report was written.

ACS contacted a neighbor who did not have concerns for the care the mother provided to the children.

After all casework activity was completed, ACS determined and closed the investigation.

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: 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
065979 - Deceased Child, Male, 2 Month(s)	065980 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
065979 - Deceased Child, Male, 2 Month(s)	065989 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
065979 - Deceased Child, Male, 2 Month(s)	065980 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
065979 - Deceased Child, Male, 2 Month(s)	065989 - Father, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
065979 - Deceased Child, Male, 2 Month(s)	065980 - Mother, Female, 28 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

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?	☐	☒	☐	☐
Explain as necessary: The surviving children did not need to be removed as a result of 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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: The family was offered bereavement services; it remained unknown if they engaged. The mother was offered Early Intervention for one of the siblings; however, she 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? Unable to Determine

Explain:
Services were offered to the children, and they anticipated they would receive services through their schools.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The mother was provided with referrals for bereavement services. It remained unknown if she utilized the service.

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

02/07/15-04/13/15 The SM and another adult were substantiated for IG and PD/AM regarding the aunts and uncles.

10/11/16-12/12/16 The SM was substantiated for IG and PD/AM of the 10yo SS. Another adult was unsubstantiated for IG of the 10yo SS.

04/11/17-06/09/17 The SM was substantiated for IG and PD/AM of the 10yo SS.

08/01/17-10/01/17 The SM was substantiated for IG and PD/AM of the 10yo SS.

10/19/17-12/19/17 The SM was substantiated for IG and IF/C/S of the 6yo SS.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Preventive Services History

On 04/16/15, a services case was opened as the mother smoked marijuana and was unable to provide adequate supervision to the siblings. The family was provided with "educational and training services", employment services, drug counseling/treatment services and case management services. The case was closed on 05/09/18, as the mother reached her goals by maintaining sobriety, taking care of the medical needs of the children, and ensuring appropriate school attendance.

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