Child Fatality Report

Report Identification Number: NY-23-094

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

Issue Date: Mar 12, 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:** Richmond **Date of Death:** 10/09/2023
Age: 3 month(s) **Gender:** Male **Initial Date OCFS Notified:** 10/09/2023

Presenting Information

New York City Administration for Children's Services (ACS) received two SCR reports on 10/9/23 that alleged, the mother placed the 3-month-old male subject child in his crib for a nap at approximately 11:00am. A short time later the mother checked on the child, and he was unresponsive and blue in color. The mother called 911 and began cardiopulmonary resuscitation (CPR) on the child. First responders arrived at the home, took over resuscitative measures, and transported the child to the hospital. The child was pronounced deceased at 12:55pm. The mother had no explanation for the death.

Executive Summary

This fatality report concerns the death of the 3-month-old male subject child that occurred on 10/9/23. The report contained the allegations of DOA/Fatality and Inadequate Guardianship against the mother. At the time of the death, the subject child resided with his mother, father, and 3-month-old twin sibling. ACS assessed the twin sibling as safe with the parents.

ACS coordinated efforts with law enforcement and learned the child was born premature at 27 weeks and was a medically fragile child. The child was diagnosed with multiple medical conditions. The child was hospitalized in the Neonatal Intensive Care Unit (NICU) from birth until his discharge on 10/3/23. The child was seen by the pediatrician on 10/5/23, for a follow-up visit. The father was at work on the day of the fatal incident and the mother was home alone caring for the children. The morning of the fatal incident at about 11:00am, the mother fed the child a bottle of formula. The mother held the child for about 15 minutes after the feeding in an attempt to get the child to burp; however, he fell asleep. The mother placed the child in the crib on his back. The mother checked on the child around 12:00pm and observed the child to be pale and unresponsive. The mother immediately called 911. The mother administered CPR on the child as directed by the 911 dispatcher, until first responders arrived at the home. Emergency medical services arrived, took over resuscitative measures, and transported the child to the hospital. Hospital staff continued life-saving measures; however, were unsuccessful and the child was pronounced deceased at 12:55pm.

An autopsy was performed; however, the final autopsy report had not yet been received at the time this report was written. ACS spoke with the medical examiner's office and the child tested negative for Covid-19 virus, Respiratory Syncytial Virus, and the influenza virus. There were no obvious signs of trauma to the child's body, and the toxicology reports were pending. The law enforcement investigation remained open pending the final autopsy; however, law enforcement noted no signs of criminality, and no arrests had been made related to the death of the subject child.

ACS offered the mother bereavement services and burial assistance, and she accepted. The mother was engaged with grief counseling services at the close of the investigation. The record did not reflect the father was fully interviewed or offered services; although, the father was seen at multiple home visits made by ACS. Maintaining separate fatality records in this case led to fragmented case recording of progress notes. ACS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother. ACS determined there was not a fair preponderance of evidence to support that the actions or inactions of the mother resulted in the child's death. ACS determined the mother provided appropriate care to the child. The CPS investigation was unfounded and closed on 12/8/23. The mother continued to engage with the voluntary preventive services case that was opened after the death.

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?** Yes

Determination:

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

Explain:
ACS made an appropriate determination based on the evidence obtained throughout the investigation.

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:
Casework activity was not commensurate with the case circumstances, the father was not fully interviewed and the Risk Assessment Profile was completed inaccurately.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The record did not reflect ACS fully interviewed the father; although, he was seen at multiple home visits and the father agreed to an interview at the 10/27/23 home visit.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make casework contacts per 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:	Case record contains information that is relevant, useful, factual and objective
Summary:	ACS maintained two fatality investigations and opened a services case after the death. Although progress notes can be copied between investigations, maintaining separate records in this case led to fragmented case recording of progress notes.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual, and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/09/2023 **Time of Death:** 12:55 PM

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

County where fatality incident occurred: Richmond
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:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] Other

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Month(s)

LDSS Response

On 10/9/23, ACS received two reports regarding the death of the SC. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. ACS assessed the safety of the twin SS and conducted an initial home visit on 10/9/23. The SM was seen and interviewed; however, the father was seen but not interviewed. The record did not reflect that EMS was contacted or interviewed as a collateral resource and maintaining separate records in this case led to fragmented case recording of progress notes.

ACS made a home visit and interviewed the SM regarding the events leading up to the SC's death. The SC was born premature with respiratory distress and a heart defect. The SC was hospitalized in the NICU from birth until his discharge on 10/3/23. The SC had a medical follow-up on 10/5/23. The SM reported she fed the SC around 11:00am and then placed the SC down for a nap in the crib. The SM went in to check on the SC at about 12:00pm, after she made a bottle for the SS, and observed the SC to be pale. The SM rubbed the SC's face to wake him up and the SC was unresponsive. The SM began screaming for the MGM that resided upstairs. The SM realized the MGM could not hear her and the SM immediately called 911. The 911 dispatcher instructed the SM to pick up the SC, place him on a flat surface, and instructed the SM on how to perform CPR on the SC until EMS arrived. EMS arrived and transported the SC to the hospital. The SS remained at the home with the MGM.

The father was seen at home visits on 10/9/23, 10/16/23, 10/23/23, and 10/27/23, and was not interviewed. Although the father was seen he was not fully interviewed regarding the allegations in the report or asked any safety and risk questions. The record reflected the father was at work at the time of the fatal incident. The father was unaware of any of the SC or twin SS's medical diagnoses or of any medical appointments. The father had no concerns for the SM's care of the children or her mental state. During a home visit on 10/27/23, the father agreed to an interview with ACS; however, the record did not reflect ACS contacted the father to set up the interview.

ACS learned the twin SS was a medically fragile child and observed the twin SS during multiple home visits. ACS was unable to interview the twin SS due to his age and assessed the twin SS as safe with the SM and father. ACS spoke with the MGM that was in the home regularly to assist the SM with the care of the twin SS, and she had no concerns for the SM's care of the children.

ACS contacted numerous collateral sources including LE, the ME, hospital staff, the pediatrician, other medical providers, and relatives. During the investigation the pediatrician and hospital staff expressed some concerns regarding the SM's mental health and possible post partum depression. The SM agreed to a mental health evaluation and engaged with bereavement services. At the close of the investigation the SS was deemed as safe with the parents. ACS unsubstantiated the allegations in the report, and unfounded and closed the CPS investigation. The mother continued to engage with the voluntary preventive services case that was opened after the death.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066469 - Deceased Child, Male, 3 Month(s)	066471 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
066469 - Deceased Child, Male, 3 Month(s)	066471 - Mother, Female, 30 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	☐	☒	☐	☐
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 ACS contacted EMS staff that responded to the home and transported the SC to the hospital as a collateral contact. ACS did not interview the father regarding the report, or safety and risk questions.

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	☒	☐	☐	☐

Explain:
The record did not reflect ACS offered the father services. The mother engaged with grief counseling services after the death of the SC.

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:
There was no removal regarding the surviving sibling.

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 provided the mother with community based resources for burial assistance and bereavement services, and the mother engaged with grief counseling services. The mother accepted Early Intervention services for the SS after the death. The record did not reflect the father was offered services.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
ACS provided the mother help with transportation to medical appointments for the twin SS after the death of the SC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided the SM with bereavement services and burial assistance resources, and the SM engaged with grief counseling. The record did not reflect ACS offered the father any 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? Yes

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/22/2023	Sibling, Male, 3 Months	Mother, Female, 29 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 3 Months	Father, Male, 34 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report that was tracked FAR alleged the twin SS was ready for discharge from the hospital for a week. The mother and father were aware the twin SS was ready for discharge and the parents failed to pick up the twin SS from the hospital. The SC remained hospitalized and was not ready for discharge.

OCFS Review Results:
The report was assigned to the FAR track, although it was unclear if the family consented to participate in FAR. The father resided in the home, was an alleged subject, and was never engaged; therefore, the reported concerns were not addressed with the father. Upon receipt of two subsequent SCR reports on 10/9/23 regarding the fatal incident, the FAR case was closed, and an investigation commenced.

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

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:
ACS did not see or engage the father regarding the concerns in the report; although, he was an alleged subject and resided in the home.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:
Family assessment response workers must work in partnership with the families participating in a family assessment response. Workers should be transparent with families regarding all actions that they take regarding the case. To the extent feasible, child protective service workers should include all family members in discussions, and any other persons the family would like to include.

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