Report Identification Number: NY-23-098

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

Issue Date: Feb 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: New York
Date of Death: 10/14/2023
Age: 7 month(s)
Gender: Male
Initial Date OCFS Notified: 10/14/2023

Presenting Information

An SCR report received on 10/14/23 alleged that on 10/13/23, at 8:00PM, the mother fed the subject child and put him in the crib to sleep at 9:30PM. Inside the crib was a few toys and a blanket. The mother then turned the light off and went to sleep. The mother checked on the child around midnight and found the child sleeping, face-down on his stomach with no issues. Around 3:00AM, the mother again checked on the child and realized the child was unresponsive. The mother immediately started performing CPR and called the police and emergency medical services (EMS). EMS arrived to the home at 3:39AM, took over CPR, and transported the child to the hospital. They arrived to the hospital at 3:52AM and the child was pronounced deceased at 4:32AM. The child was otherwise healthy and the mother did not have an explanation for the child's death.

Executive Summary

This report concerns the death of the 7-month-old subject child. The Administration for Children's Services (ACS) received an SCR report on 10/14/23 regarding the child's death. At the time of the child's death, he resided with his mother. The child's father lived separately and there was an Order of Protection against the father on behalf of the mother and child.

On the evening of 10/13/23, the mother placed the subject child in his crib to sleep around 9:30PM. The child was placed to sleep on his back, and the crib contained a blanket, plastic toys, and a tablet. The mother next checked on the child at midnight, and the child was asleep and still on his back. The mother went back to sleep. At 3:00AM, the mother woke up again and noticed the child was not making any noise and would normally have cried for his bottle by that time. She got up and went to the crib and found the child lying face-down on his stomach. The mother began screaming for help and shelter staff called 911. EMS responded to the home and found the child unresponsive, not breathing, and without a pulse. CPR was initiated, sustained en route to the hospital, and continued by emergency department staff for 30 minutes upon arrival to the hospital. The child did not respond and was pronounced deceased at 4:32AM.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending when the CPS investigation was closed. Preliminary findings showed no signs of trauma and no signs of congenital or macroscopic abnormalities. A re-enactment was performed on 10/14/23; however, the medical legal investigator would not share their assessment until the results of the autopsy were received. Hospital staff confirmed there were no visible signs of trauma or injury to the child upon arrival. The child had been intubated in the field by EMS and arrived unresponsive, not breathing, pulseless, and in cardiac arrest. The record did not reflect either the medical examiner, medical legal investigator, or emergency department staff were asked about what, if any, role the child's sleeping environment may have played in the death.

Law enforcement investigated and at the time the CPS investigation was closed, the death was considered non-criminal and law enforcement was awaiting the final autopsy report.

ACS interviewed the mother, father, family, and collateral contacts, none of whom expressed concerns for the mother's care of the child.

The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the mother regarding the death of the child. The parents were accepting of receiving resources for bereavement services; however, it was unknown

if either parent engaged in services.

PIP Requirement

For citations identified in historical cases, ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:

There were no surviving siblings or children residing in either of the parents' homes; therefore, the Safety Assessment tools were not applicable.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:

The mother and father were provided resources for services in response to the fatality. As there were no children residing in either home and no additional service needs were identified, the case was closed. At the time of closing, the final autopsy remained pending as the outstanding test results had not yet been received.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/14/2023 **Time of Death:** 04:32 AM

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

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 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	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Other Household 1	Father	No Role	Male	39 Year(s)

LDSS Response

On 10/14/23, ACS received a report regarding the death of the subject child. ACS initiated their investigation within 24 hours and coordinated 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 completed interviews with the mother and father separately, and assessed the mother's room at the shelter and observed the child's sleeping arrangements. The mother did not return to residing in the shelter following the child's death and there were no siblings.

ACS interviewed the mother regarding the events leading up to the child's death. On 10/13/23, the mother had been running errands with the child during the day and they ate dinner at her sister's home that evening prior to returning to the shelter. The mother stated the child had a runny nose and had been coughing after having received multiple vaccinations and the flu shot on 10/11/23. The mother could not recall the specific time they returned home but had placed the child in his crib at 9:30PM. The mother was asked about items in the child's crib and stated there were some toys, as the child would play prior to falling asleep, and a blanket on his bottom half. The mother was aware of safe sleep recommendations and placed the child to sleep on his back. When she woke up at midnight on 10/14/23, she noticed the child was still asleep and still on his back. The mother went back to sleep at that time and woke again at 3:00AM. The mother got up and went to the crib to check on the child and found him face-down, lying on his stomach. The mother screamed for help. The mother was unable to recall if the child was covered with the blanket when she found him unresponsive.

ACS learned overnight shelter staff made the 911 call. The shelter director and the mother's caseworker were spoken to;

however, the record did not reflect the staff responding to the incident were interviewed. The shelter staff expressed no concerns for the mother's care of the child. The mother was engaged in DV counseling, both individual and group, through the shelter. The status of those services was unknown once the mother relocated from the shelter. The mother had multiple family supports with her following the fatality. ACS spoke with family members who all expressed no concerns for the mother. The father was seen and interviewed. There was an active Order of Protection on behalf of the mother and child, and the father had not seen the child in about two months. The father was alerted of the child's critical status by a family member and was informed by a doctor at the hospital of the child's death.

The child's immunization history was obtained, which confirmed the child received multiple vaccinations as reported by the mother. The pediatrician's office was contacted and the only information they would provide was that the child was up to date with all well-child visits and immunizations and there were no concerns noted. The mother reported the child was overall a well child, he had no allergies, medical concerns, or preexisting conditions. Additional medical records received indicated; however, that the mother had expressed concern at the 10/11/23 appointment that the child would cry inconsolably for 20 minutes and sometimes bang his head on the floor. This was not further explored with the pediatrician or mother.

ACS contacted numerous collaterals, including the pediatrician, hospital, law enforcement, the medical examiner's office, shelter staff, and requested records from first responders. At the close of the investigation the final autopsy remained pending and law enforcement was awaiting the final report. Due to their history, the parents were provided with resources for both DV and bereavement services and the case closed on 12/13/23.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065748 - Deceased Child, Male, 7 Month(s)	065750 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
065748 - Deceased Child, Male, 7 Month(s)	065750 - 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?	☒	☐	☐	☐
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:
Records were requested from first responders; however, were not documented to have been received. There were no conversations with EMS. Shelter staff who responded on the night of the fatal incident and called 911 were not 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.

Have any Orders of Protection been issued? No

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 mother received DV counseling through the shelter; however, upon the mother's relocation, it was unknown if those services continued.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
DV, mental health, and medical consultations were held and it was recommended the parents be separately referred to DV and bereavement services. Both parents were accepting of receiving information on relevant resources. ACS provided both parents with DV and bereavement resources prior to closing the case. It was unknow if the parents engaged in services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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
- ☐ With fetal alcohol effects or syndrome
- ☐ Exhibiting withdrawal symptoms
- ☒ 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)	Allegation Outcome	Compliance Issue(s)
08/17/2023	Deceased Child, Male, 5 Months	Father, Male, 39 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 5 Months	Father, Male, 39 Years	Other	Substantiated	
	Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Other	Unsubstantiated	

Report Summary:
ACS received an SCR report on 8/17/23 due to a court-ordered investigation (COI). The allegation of Other referred to the COI. Additionally, it was alleged the father had a history of violence in the home. The father regularly threatened to kill the mother while in the presence of the child. In early July 2023, the father threatened to kill the mother and child with a knife. The father also hit and squeezed the child’s head. It was unknown if the child sustained injuries at that time.

Report Determination: Indicated | **Date of Determination:** 09/27/2023

Basis for Determination:
The allegation of IG against the father was substantiated, as the father was found to have been physically abusive toward the mother in the presence of the child, to the point an Order of Protection was issued. The father hit the mother while she was pregnant with the child, resulting in the mother being hospitalized, and there was an incident in which the father squeezed the child’s head and tossed him onto a bed. The allegation of Other was incorrectly substantiated against the father. Allegations against the mother were unsubstantiated.

OCFS Review Results:
The investigation was initiated timely, and the child’s safety was routinely assessed through weekly visits to the mother and child in their place of shelter. The father denied access to his home and was therefore interviewed over the telephone. Not all supervisory guidance was completed, such as offering the mother PPRS, reaching out to the pediatrician, or gathering more information from the mother regarding the incident in which the child was physically harmed by the father and medical attention was sought. Family court was ongoing at the time the CPS investigation closed and had been adjourned to December 2023 for a settlement conference.

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

Issue:
Adequacy of Progress Notes

Summary:
Supervisory and summary notes alluded to casework activities having been completed that were not otherwise reflected in progress notes.

Legal Reference:
18 NYCRR 428.5

Action:
ACS will accurately document all casework activity into progress notes.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The Safety Assessment due at the time of determination reflected No Safety Factors Present; however, the controlling interventions of an Order of Protection and confidential shelter for the mother and child were still in place.

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:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The father, a confirmed subject of the report, was not identified as a caretaker, therefore, the RAP score did not reflect an assessment of risk regarding the father.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Issue:

Appropriateness of allegation determination

Summary:

If an investigation of a report where the listed allegation is “Other” results in a finding of fair preponderance of evidence of abuse or maltreatment, the report should not be substantiated as “Other”; rather, the appropriate allegation should be selected.

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 NYC Regional Office if further guidance is needed.

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?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The 8/17/23 CPS investigation was initiated by the mother filing for sole custody of the child in family court. A Court-Ordered Investigation was requested and due to court on 9/5/23. The following court appearance on 9/12/23 was adjourned to 9/18/23, and that appearance was subsequently adjourned to 12/4/23 for a settlement conference. The child died prior to the 12/4/23 appearance date.	

Have any Orders of Protection been issued? Yes	
From: 08/04/2023	**To:** 12/04/2023

Explain:
An Order of Protection was issued against the father on behalf of the mother and child on 8/4/23. Records reflected the Order of Protection expired on 9/12/23. Another temporary Order of Protection was issued on 9/18/23, to remain in effect until 12/4/23 (the next scheduled appearance date). The father was ordered to stay away from the mother and subject child; the home of the mother and subject child; refrain from communication or any other contact with the mother and child including third-party contact; and refrain from assault, stalking, harassment, etc. of the mother and subject child. The Order was subject to further orders of custody and/or parenting time issued by a court. It was unknown if the Order was extended on behalf of the mother.

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