



Report Identification Number: NY-23-100

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

Issue Date: Feb 29, 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
Age: 2 year(s)

Jurisdiction: Kings
Gender: Male

Date of Death: 10/15/2023
Initial Date OCFS Notified: 10/15/2023

Presenting Information

An SCR report alleged that on 10/15/23 at about 7:30 PM, the mother put the 2-year-old subject child in his bed because he was not eating. At about 10:50 PM, the mother sent the 10-year-old sibling to check on the child and the sibling discovered that the child was not breathing. The sibling informed the mother of this, and the mother called 911 at 10:52 PM. Emergency medical services responded to the home and performed cardiopulmonary resuscitation on the child, but their attempts were unsuccessful. The child was transported to the hospital where he was pronounced deceased. The child was otherwise healthy and the mother had no explanation for his death.

Executive Summary

This fatality report is regarding the death of a 2-year-old male child that occurred on 10/15/23. An SCR report was made on the same day and included allegations of Inadequate Guardianship and DOA/Fatality against the mother. The child resided with his mother and 10-year-old sibling. The father visited with the child but did not reside in the home. The family did not have any previous child protective services involvement. The 10-year-old was determined to be safe in the care of the mother.

The Administration for Children's Services (ACS) initiated their investigation and gathered information regarding the death from the family and collaterals. It was learned that the subject child had medical conditions that he was diagnosed with in utero. The medical conditions impacted his mobility and nutrition. The mother reported the child saw a pediatrician and a neurologist. On the day of the death, the child was home with the mother and sibling after spending the night at the maternal grandmother's house. The maternal grandmother reported the child did not want to eat while he was with her, which was typical of him at times due to his nutrition issues. Around lunchtime, the child still did not want to eat, so the mother placed the child in his bedroom to rest while she cleaned the home. The father was in the living room watching television. The mother asked the sibling to periodically check on the child. The sibling checked on the child and discovered he was cold to touch and not breathing. The sibling alerted the parents. The mother ran into the room and confirmed the child was unresponsive. First responders were called and the mother performed CPR until their arrival. Emergency medical services responded and continued life-saving measures en route to the hospital where the child was pronounced deceased.

An autopsy was completed; however, the final results were pending further studies at the time this report was written. The physician at the hospital reported there was a strong possibility that the child's death may have been related to his medical conditions. Law enforcement investigated the fatality and ACS inquired about their investigation on 10/16/23. At that time, law enforcement suspected no criminality as the child had a variety of medical conditions.

ACS unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the mother as they did not find a preponderance of evidence to support the allegations. ACS determined the child was diagnosed with multiple medical conditions. ACS spoke to collaterals who reported no concerns for the mother's care of the child and who reported the mother tended to the child's medical needs. Fatality related services were offered to the family and a preventive services case was opened to provide ongoing support. The investigation was unfounded and closed on 12/14/23.

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?** 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:

The safety of the 10-year-old sibling was assessed throughout the investigation. A determination was made in congruence with the evidence gathered.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:

Though documented within the services case, the CPS investigation did not contain a record of a home visit to the case address. In addition, pertinent medical collaterals were not contacted regarding the child's medical conditions.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The child was medically fragile with multiple medical conditions. Though ACS made efforts to gather information from the pediatrician, the record did not reflect information was obtained before case closure, nor was the child's neurologist contacted.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.



Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/15/2023

Time of Death: Unknown

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:

10:52 PM

Did EMS respond to the scene?

Yes

At time of incident leading to death, had child used and/or ingested alcohol or drugs?

N/A

Child's activity at time of incident:

- Sleeping
- Playing
- Other

- Working
- Eating

- Driving / Vehicle occupant
- Unknown

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	2 Year(s)
Deceased Child's Household	Father	No Role	Male	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)

LDSS Response

Upon receipt of the SCR report on 10/15/23, ACS coordinated their investigation with law enforcement, sent notification to the Medical Examiner and District Attorney, interviewed the family, and offered the family fatality-related services.

ACS interviewed the mother regarding the fatal incident. The mother reported the child was at the grandmother's home the day before the death and would not eat. The mother picked up the child the next day and made him lunch, which he refused to eat. The mother laid the child down on his side for a nap and began cleaning the home. The mother asked the sibling to periodically check on the child and reported it was typical to check on the child while he slept. The sibling went to check on the child and returned and told the mother the child was not breathing. The mother ran into the room and checked to see if the child's throat was obstructed. The mother began CPR and noticed milk coming out of his nose. EMS



arrived and found a slight pulse, but the child was later pronounced deceased at the hospital.

Following the death, ACS documented a visit to the relatives home where the mother and sibling were temporarily residing. Once the mother and sibling returned to their home, ACS completed a visit; however, this was documented in the services case and not the CPS investigation. There were no concerns for the home's condition. The sibling was interviewed and reported the child did not have any issues on the day of his death. The mother asked the sibling to check on the child so he went into the child's bedroom and saw he was not breathing and was cold to the touch. The sibling alerted the parents. The father participated in a meeting documented within the preventive services case following the death; however, an interview with him was not documented in the CPS investigation case record.

ACS interviewed the maternal grandmother who confirmed the child was with her the night before his death. The grandmother said nothing was out of the ordinary with the child's behavior. The maternal grandmother explained the child did not eat, but that was not out of the ordinary, as some days he would eat and some days he would not eat. The grandmother had no concerns for either child and said that the mother stayed on top of everything with the children.

ACS interviewed hospital personnel who reported the child appeared malnourished and had no pulse upon his arrival at the hospital. It was further stated that the child was born with mobility and feeding issues. The child was fed via a feeding tube since he was two weeks old, which likely accounted for his malnourished appearance. The hospital reported they did not provide regular care for the child. The mother reported the child had a medical disorder that he was diagnosed with when he was in utero. The mother was told the condition was not life-threatening and she did not believe he was to have a premature death as a result of it. The child was awaiting testing for his condition and she intended to have a discussion with the pediatrician regarding the child's expected length of life. ACS contacted the pediatrician to confirm the child was a patient and requested records twice; however, records were not received at case closure and further information about his conditions and receipt of appropriate care were not documented. The mother reported that in addition to his pediatric appointments the child saw a neurologist. ACS contacted one hospital who reported the child did not show for his new patient appointment in 2021. The record did not reflect contact with the neurology office at which the mother reported the child received care.

The mother reported a need for assistance with the funeral expenses and grief counseling. ACS provided the family with the appropriate referrals, and a Preventive Services case was opened to assist the family with fatality related services.

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: NYC does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066208 - Deceased Child, Male, 2	066209 - Mother, Female, 31	DOA / Fatality	Unsubstantiated



Child Fatality Report

Year(s)	Year(s)		
066208 - Deceased Child, Male, 2 Year(s)	066209 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

The record did not reflect the child's neurologist was contacted nor was there an interview documented with the father in the CPS investigation.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
 Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

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