Child Fatality Report

Report Identification Number: NY-23-108

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

Issue Date: Apr 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 11/03/2023
Initial Date OCFS Notified: 11/03/2023

Presenting Information

The SCR report alleged that on 11/3/23, around 8:40 AM, the father was holding and feeding the subject child. While being fed, the subject child began to gag and became unresponsive. The father immediately called emergency medical services and performed cardiopulmonary resuscitation. Emergency medical services arrived at the home at approximately 8:50 AM and continued to perform cardiopulmonary resuscitation on the subject child. The subject child was transported to the hospital and pronounced deceased at 9:30 AM. The subject child was an otherwise healthy child.

Executive Summary

This fatality report concerns the death of the 3-month-old subject child that occurred on 11/3/23. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the father. At the time of her death, the subject child resided with her mother, father, 2-year-old sibling, and multiple paternal relatives including four cousins, ages 17, 12, 6, and 6.

The Administration for Children's Services (ACS) completed casework and collateral activity and learned that on 11/3/23, the subject child was fed and placed into her stroller. An unknown amount of time later, the subject child was found unresponsive in her stroller. A paternal aunt who was home at the time of the incident performed cardiopulmonary resuscitation while the father called 911. Emergency medical services responded to the residence, continued life-saving measures, and transported the father and subject child to the hospital where she was later pronounced deceased.

There was no autopsy completed due to the family's religious preferences. The medical examiner completed an external exam of the subject child and noted no concerns. Microbiology testing was completed, and the subject child was positive for Human Rhinovirus. There was no cause of death; however, the medical examiner did note that based on the external exam the manner of death appeared to be natural. The law enforcement investigation was closed, and no arrests were made related to the death of the subject child.

ACS offered fatality-related services to the parents, though they stated they were utilizing familial support. The surviving sibling and other children in the household were deemed safe in the care of their respective parents. The allegation of Inadequate Guardianship was predetermined. There were discrepancies regarding the timeline leading to the subject child being discovered unresponsive, who discovered the child, and if the stroller was being utilized for sleeping; however, these concerns were not further explored with the father. Diligent efforts were not made to contact the pediatrician and all household members were not interviewed. The 30-Day Safety Assessment was not completed. The CPS investigation was unfounded and closed on 1/4/24.

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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

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 case circumstances, as the allegation of IG was predetermined and all appropriate collateral sources were not contacted.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	The allegation of IG was predetermined. ACS obtained conflicting information regarding the timeline, the stroller being utilized for sleeping, and who initially found the SC unresponsive; however, these discrepancies were not further explored.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect diligent efforts to contact the pediatrician to discuss the SS's recent illness and SC's upcoming appointment, despite the SC being ill in the days preceding her death. Not all household members were interviewed.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it

	pertains to safety, risk, and a determination of the allegations.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	Though safety was assessed, the 30-Day Safety Assessment was not completed in CONNECTIONS.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must complete a safety assessment at 30 days for reports of a child fatality, unless there are no surviving siblings or children in the household.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/03/2023 **Time of Death:** 09:30 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	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their efforts with LE, interviewed the parents, assessed the safety of the

SS, and contacted collateral sources.

ACS interviewed the SF and learned that on 11/3/23, the SF brought the BM to work with both the SC and SS. The SF reported that he returned home with the children around 8:15-8:20 AM and the SC was crying. The SF fed the SC approximately 1 ounce of formula, stating the SC ate 2 hours prior around 6:20 AM. The SF then placed the SC in her car seat, which extended to become a stroller. The SF reported that 5 minutes after feeding the SC, he checked on her and the SC had milk coming out of her nose. The SF stated he picked the SC up and put her upside down while patting her back in an attempt to clear any obstruction. The PA who resided in the home and was a registered nurse began CPR and the SF called 911. EMS arrived, continued resuscitative efforts, and transported the SC and SF to the hospital. The SC was pronounced deceased at 9:30 AM.

The PA who was present was interviewed and reported conflicting information. The PA stated she came downstairs to play with the SC and observed the SC in her stroller. The PA stated the SC was not responding to her, so she picked the SC up and the SC was limp, and her lips were blue. The PA stated she checked for a pulse; however, did not feel one and began CPR while the SF called 911. The PA reported while she was performing CPR, there was milk coming out of the SC's nose and mouth. The medical examiner reported additional varying information that the SC was put down for a nap in the stroller and had been placed in the stroller for 30 minutes. These discrepancies were not further explored. The BM was at work at the time of the incident and was made aware of the SC's condition when the SF called her and had no further information regarding the fatal incident. The record did not reflect specifically which household members were home at the time of the incident, and therefore, it is unknown if all parties present at the time were interviewed.

The SF reported the SC was ill a week prior to and on the days preceding her death. The SF stated the SC had been coughing and had a fever. The SC was given a fever reducer but was not seen medically, though the SF stated the SC had a scheduled appointment with the pediatrician on 11/7/23. The SF reported the SS had similar symptoms a week before the SC and was seen by the pediatrician. The record did not reflect that diligent efforts were made to speak with the pediatrician regarding the SS's recent illness and the SC's upcoming appointment.

The surviving children in the household were deemed safe in the care of the adults residing in the home. There were no service needs identified.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066638 - Deceased Child, Female, 3 Month(s)	066640 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated

066638 - Deceased Child, Female, 3 Month(s)	066640 - Father, Male, 37 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 that all adult household members were spoken to. It was unclear based on the record who was home at the time of the incident, and therefore, it was unknown if all parties present at the time were spoken to.

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: No children needed to be removed following the death of the SC.				

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 parents were offered MH services; however, they declined stating they were utilizing familial support. The record did not reflect that burial assistance was offered, despite supervisory directive to do so; however, the SC was buried outside of the country in the family's country of origin.

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? No
Explain:
Due to age and development of the SS, no fatality-related services were provided to the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were offered MH services; however, stated they were utilizing familial support following the death of the SC.

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
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco

- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

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

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known history outside of New York State.

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