Child Fatality Report

Report Identification Number: NY-23-113

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

Issue Date: Apr 24, 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		

Office of Children and Family Services

Child Fatality Report

Case Information

Report Type: Child Deceased | **Jurisdiction:** Kings | **Date of Death:** 11/13/2023
Age: 2 year(s) | **Gender:** Male | **Initial Date OCFS Notified:** 11/13/2023

Presenting Information

On 11/13/23, 2 SCR reports alleged on 11/12/23, the 2-year-old child (SC) was put to sleep in a playpen in the lower level of the home at about 7:30pm. Around 10:00pm, the mother (SM) checked on the child and covered him with a blanket. On 11/13/23, around 7:50am, the SM found the SC face down in the playpen. The SC had a laceration to the corner of his left eye, and there was blood on the pillow. The SC was nonresponsive, and the SM immediately called 911. First responders arrived and began CPR. The SC's body was already in a state of rigor mortis. CPR was stopped and the SC was declared deceased at 8:03am. The SC was an otherwise healthy child. The parents and the other adult had no explanation for the SC's death.

Executive Summary

This fatality report is regarding the death of a 2-year-old male child which occurred on 11/13/23. New York City Administration for Children's Services (ACS) received 2 SCR reports the same day with allegations of DOA/Fatality, Inadequate Guardianship, and Lacerations, Bruises, Welts against the mother, the father, and the other adult (OA). At the time of the death, the child resided with his mother, father, and 3-year-old sibling. ACS assessed the sibling to be safe in the care of the parents.

ACS coordinated investigative efforts with law enforcement and learned the night prior to the death, the child was put to bed around 7:30pm. The mother checked on the child at about 10:00pm and covered him with a blanket. The morning of the death, the mother checked on the child at about 7:45am and found the child face down, bluish in color, and unresponsive. The mother called out to the father, and he immediately called 911. The father began cardiopulmonary resuscitation on the child as directed by the 911 dispatcher until first responders arrived at the home. First responders arrived and took over resuscitative measures; however, were unsuccessful and the child was pronounced deceased at the home at 8:03am. The child's body was transported to the medical examiner's office.

ACS contacted the medical examiner's office, and an autopsy was performed. The cause of death was "multiple respiratory viral infection (SARS-COV-2, Parainfluenza Virus 3, Human Rhinovirus/Enterovirus) in child with DEP domain-containing protein 5 (DEPDC5) variant of uncertain significance", and the manner of death was natural. The medical examiner reported there were no physical signs of abuse to the child. Law enforcement found no criminality regarding the death of the child and the criminal investigation was closed.

ACS offered the family bereavement services, burial assistance, and completed a referral for play therapy for the sibling; however, the parents declined the services and stated the family had familial and community supports. ACS provided the parents with a list of community-based resources. ACS unsubstantiated the allegations of DOA/Fatality, Inadequate Guardianship, and Lacerations, Bruises, Welts against the mother, the father, and the other adult. ACS determined there was not a fair preponderance of evidence to support that the actions or inactions of the mother, father, and other adult resulted in the child's death.

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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

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:
Casework activity was commensurate with the case circumstances.

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: 11/13/2023 **Time of Death:** 08:03 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? No

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	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Other Adult - Nanny	Alleged Perpetrator	Female	63 Year(s)

LDSS Response

On 11/13/23, ACS received 2 reports regarding the death of the SC. ACS initiated their investigation within 24 hours and coordinated their efforts with LE. ACS contacted the sources of the reports, completed a CPS history check regarding the family, and informed the DA of the fatality. ACS assessed the safety of the SS and conducted an initial home visit on 11/13/23. All adults on the report were interviewed and collateral sources were contacted.

ACS interviewed all the adults regarding the events leading up to the SC's death. The SF had taken the SC to the park 2 days prior to the death, and the SC fell forward going up the stairs of the slide. The father immediately sought medical attention and the SC was treated and released. The day prior to the death, the family went on their routine visit to the park. The SC acted like himself, and the parents had no concerns for the SC. Later that evening, the mother fed and bathed the children, and the babysitter watched the children while the parents went out around 7:30pm. The parents got home around 10:00pm and the SM tucked both children in. The SC had been sleeping in the lower level bedroom for a few weeks due to having difficulty sharing a room with the SS, and the SC wanted to sleep on the lower level of the home. The SM woke up the SS the morning of the death and then went to wake the SC. The SM reported she found the SC face down on his stomach, limp, bluish in color and unresponsive. The mother noticed some blood on the pillow. The SM yelled for the SF and carried the SC to the kitchen. The SF met the SM in the kitchen and immediately called 911. The SF was instructed by the dispatcher how to perform CPR until first responders arrived. The SM and SF reported there was nothing out of the ordinary with the SC and the SC in the few days prior to his death. ACS observed the room on the lower level of the 3-story home where the SC slept, and there were no concerns for the room. Appropriate sleeping arrangements were observed, no safety hazards, and a camera for the parents to observe the SC was seen.

ACS observed and attempted to interview the SS, and he had no visible marks or bruises. The SS was verbal, and ACS engaged with the SS at the home visit on 11/13/23. The SS was assessed as safe with the parents. The parents reported the SS was with the OA in another room the morning of the fatal incident.

ACS interviewed the OA who did not reside in the home and was employed as the nanny who reported to work around

8:00am the morning of the death. The OA reported she was in the kitchen preparing the SC and SS's bags and the SS was in the highchair getting ready to have breakfast. The OA heard a loud scream and saw the SM carrying the SC up the stairs to the kitchen. The OA observed the SC to appear bluish in color. The SF came down from upstairs. The OA took the SS into another room and closed the door, and stayed with the SS. The OA heard the SF call 911 and the SF performed CPR until first responders arrived. The OA had no concerns for the parent's care of the children and had no other information regarding the child's death.

ACS contacted collateral sources including EMS, LE, and the ME. LE and the ME verified the SC was seen medically regarding the cut near the SC's eye. The children's pediatrician and school staff, who reported no concerns for the children or the parent's care of the children. At the close of the investigation, the sibling was deemed safe with the parents. ACS unsubstantiated the allegations in the report, and unfounded and closed the case.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
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
067019 - Deceased Child, Male, 2 Year(s)	067023 - Other Adult - Nanny, Female, 63 Year(s)	DOA / Fatality	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067020 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067023 - Other Adult - Nanny, Female, 63 Year(s)	Inadequate Guardianship	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067021 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067020 - Mother, Female, 34 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067021 - Father, Male, 35 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067023 - Other Adult - Nanny, Female, 63 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067020 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
067019 - Deceased Child, Male, 2 Year(s)	067021 - Father, Male, 35 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?	☒	☐	☐	☐

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:
There was no removal regarding the SS.

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 offered the family bereavement services, burial assistance, and completed a referral for play therapy for the sibling. The parents declined the services and stated the family had familial and community supports. ACS provided the parents with a list of community-based resources.

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:
ACS made a play therapy referral for the SS; however, the parents declined the services. The family engaged the SS with services in their community.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS offered the parents bereavement services and burial assistance, and the parents declined the services. The parents reported having familial and community supports.

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 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