



Report Identification Number: NY-23-117

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

Issue Date: May 06, 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: 9 month(s)

Jurisdiction: Queens
Gender: Male

Date of Death: 11/30/2023
Initial Date OCFS Notified: 11/30/2023

Presenting Information

The SCR report alleged that on 11/29/23, the mother and father placed the subject child in bed with them to co-sleep. The subject child was placed between the wall and the mother. On 11/30/23, at approximately 2:50 AM, the father awoke to find the subject child cold and unresponsive. The father immediately called 911. Emergency medical services arrived and began cardiopulmonary resuscitation. The subject child was transported to the hospital and arrived at approximately 3:00 AM. The subject child was pronounced deceased at 3:27 AM. The report stated the unsafe sleep conditions contributed to the subject child's death.

Executive Summary

The Administration for Children's Services (ACS) received a report concerning the death of the 9-month-old subject child who died on 11/30/23. At the time of the child's death, he resided at home with his mother and father. There were no surviving siblings or other children in the home.

The investigation revealed the subject child was unwell on the day preceding the death. The parents brought the child to the hospital because he had vomited several times throughout the day. The child presented with a fever and was treated for a viral infection, prescribed medication, and discharged home to the care of his parents. At approximately 10:00 PM, the subject child was placed in bed with the mother and father. At 2:50 AM, the father used the restroom and checked on the subject child who was cold to the touch. The father immediately called 911 and first responders arrived at the home and transported the subject child to the hospital where he was pronounced deceased at 3:27 AM.

ACS coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final autopsy report was not yet received at the time this report was written. The criminal investigation remained open as the final autopsy report was pending; however, law enforcement did not suspect criminality.

ACS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, the medical examiner, and relatives. ACS provided fatality-related services to the family upon receipt of the fatality report. At the time of this writing, the CPS investigation remained open.

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** The CPS report had not yet been determined at the time this Fatality report



investigation?

was written.

- Was the determination made by the district to unfound or indicate appropriate?

N/A

Explain:

The CPS investigation remained open, and therefore, no determination had been made.

Was the decision to close the case appropriate?

N/A

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 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: 11/30/2023

Time of Death: 03:27 AM

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

Unknown

County where fatality incident occurred:

Queens

Was 911 or local emergency number called?

Yes

Time of Call:

02:48 AM

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



Child Fatality Report

Deceased Child's Household	Deceased Child	Alleged Victim	Male	9 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

On 11/30/23, ACS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, ACS initiated their investigation within 24 hours and coordinated efforts with their MDT.

ACS interviewed the parents and learned that the subject child had vomited multiple times on the morning of 11/29/23. The mother transported the child to the hospital around 11:00 AM as the father was at work. The mother was provided medication and sterilized water upon discharge from the hospital. The mother reported the child was no longer vomiting upon their return home, but he was not active, refused to eat, and had a fever. The mother reported that she and the father co-slept with the child that night because she wanted to check on him throughout the night as he was feeling unwell. The mother showed ACS the crib for the subject child and reported he regularly slept alone in the crib. The mother reported she and the father checked on the subject child throughout the night and observed him to be unresponsive around 2:50 AM. At that time, the father called 911 and they were transported to the hospital. Both parents acknowledged an understanding of safe sleep practices and reported they consistently adhered to safe sleep guidance.

ACS spoke with medical professionals and learned the subject child was seen at the hospital on 11/29/23 for a viral infection and discharged home to the parents with medication. Hospital records reflected that the parents co-slept with the subject child and the sleeping arrangement was as follows: the subject child was placed closest to the wall, then the mother, and lastly the father in the bed. Further information from medical personnel revealed the father and subject child arrived at the hospital at 3:05 AM and the subject child was in cardiac arrest. Resuscitative attempts were unsuccessful, and the child was declared deceased at 3:27 AM.

At the time of this writing, the CPS investigation remained open. The final autopsy had not yet been received and the criminal investigation remained open. Fatality-related services were provided to the family, but it was unknown if they were being used.

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
066914 - Deceased Child, Male, 9	066915 - Mother, Female, 33	DOA / Fatality	Pending



Month(s)	Year(s)		
066914 - Deceased Child, Male, 9 Month(s)	066915 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Pending
066914 - Deceased Child, Male, 9 Month(s)	066916 - Father, Male, 39 Year(s)	DOA / Fatality	Pending
066914 - Deceased Child, Male, 9 Month(s)	066916 - Father, Male, 39 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input checked="" 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"/>
Pediatrician	<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 checked="" type="checkbox"/>	<input 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"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<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	Offered,	Offered,	Not	Needed	N/A	CDR
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Child Fatality Report

	After Death	but Refused	Unknown if Used	Offered	but Unavailable		Lead to Referral
Bereavement counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>

Additional information, if necessary:

A referral to bereavement counseling was made on behalf of the parents; however, it was unknown if the parents were engaged in services. The record did not reflect the parents were offered burial assistance.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

ACS made referrals to grief counseling on behalf of the mother and father. It was unknown if the parents utilized services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?

No

Was the child acutely ill during the two weeks before death?

Yes

Infants Under One Year Old

During pregnancy, mother:



- Had medical complications / infections
- Misused over-the-counter or prescription drugs
- Experienced domestic violence
- Had a positive toxicology at the time of delivery
- Used marijuana
- Had heavy alcohol use
- Smoked tobacco
- Used illicit drugs
- Used prescription drugs
- Was not noted in the case record to have any of the issues listed

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

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 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