Child Fatality Report

Report Identification Number: NY-23-120

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

Issue Date: Mar 26, 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: Queens
Date of Death: 12/11/2023
Age: 2 month(s)
Gender: Male
Initial Date OCFS Notified: 12/11/2023

Presenting Information

An SCR report received on 12/11/23 stated that the mother fed the subject child at approximately 4:00AM and placed him face-down on the mother's bed to sleep. The mother woke up at approximately 9:00AM and found the child unresponsive. The mother attempted cardiopulmonary resuscitation (CPR) and called 911 at approximately 9:23AM. When emergency medical services (EMS) arrived, the child was blue in color, and had been placed face-up at the foot of the bed. EMS performed CPR on the child at the home and in the ambulance. The child was intubated in the ambulance and transported to the hospital, where he was pronounced dead at 10:06AM. The child was an otherwise healthy child. The mother was the primary caretaker to the child and had no explanation for his death.

Executive Summary

This report concerns the death of the two-month-old subject child. The Administration for Children's Services (ACS) received an SCR report regarding the child's death on 12/11/23. At the time of the child's death, he resided with his mother and 14-year-old half-sibling. The child's father resided separately; however, did visit with the child.

On the evening of 12/10/23, the mother, subject child, sibling, and maternal grandmother were home and watching a movie. After the movie ended, around 10:00PM, the family went to sleep. The mother regularly co-slept with the child on a twin-sized mattress and did so the evening of 12/10/23. There was a crib available to the child; however, the mother stated the child "hated" the crib and would cry when placed on his back in the crib. The shared bed contained two pillows at the head of the bed, two comforters, and an additional pillow used to prevent the child from rolling over into a gap between the bed and wall. That evening, the mother positioned the child next to the pillow used to block the gap, on his left side, facing the pillow. The child woke periodically throughout the overnight hours for feedings. The mother recalled at 7:00AM the following morning, the child grunted and cried. The mother got up and made a bottle; however, the child did not take it and the mother went back to sleep. The mother next woke up around 9:00AM. She noticed the bed was wet though had not paid attention to it and proceeded to wake the child. Typically, the child would respond to the mother tapping him by arching his back; however, she did not receive a response and tried again. The mother then picked up the child and saw his lips were blue and his eyes were closed. The mother called to the grandmother for help. The grandmother came into the room, took the child from the mother, and instructed the mother to call 911 while the grandmother began CPR. EMS responded and transported the child to the hospital, where he was pronounced deceased at 10:06AM.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed. The medical examiner reported there were no injuries found, further testing was expected to take four to five months, and the autopsy report would be available in six to eight months. The medical examiner was made aware of the unsafe sleep environment; however, was not asked and offered no input as to the sleep environment's relation to the death. Law enforcement investigated and found no criminality, though their investigation remained open pending receipt of the death certificate.

ACS made several home visits and interviewed the mother, father, grandmother, and sibling. The sibling's father was not identified during the investigation. The sibling was assessed to be safe in the mother's care.

ACS substantiated the allegations against the mother regarding the death of the child. The Investigation Conclusion Narrative stated interviews with the mother, the reported sleep environment, the mother's knowledge of safe sleep

practices and subsequent failure to comply with safe sleep practices supported the substantiation of Inadequate Guardianship and DOA/Fatality. However, the receipt of safe sleep counseling should not impact the determination and there was missed opportunities to inquire of the medical examiner as to whether the death was caused by the actions of the mother; therefore, causation was not established to support DOA/Fatality.

The mother accepted burial assistance and continued to receive mental health services through a previously established provider. The sibling and father declined services.

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?** — Yes

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:

The determination to indicate the overall investigation was appropriate; however, the missed opportunities to gather sufficient information from medical providers regarding the child's cause of death led to an inaccurate determination regarding the DOA/Fatality allegation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Although direct contact was made with the ME, substantive questions regarding a preliminary cause of death were not explored; therefore, causation was not established regarding the mother's role in the child's death.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/11/2023

Time of Death: 10:06 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: 09:23 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:

- [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 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Male	14 Year(s)
Other Household 1	Father	No Role	Male	49 Year(s)

LDSS Response

On 12/11/23, ACS received a report regarding the death of the subject child. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history

check which revealed no prior CPS involvement, and informed the DA of the fatality. ACS assessed the safety of the surviving sibling and conducted an initial home visit the day the report was received.

ACS interviewed the mother regarding the events leading up to the child's death. The mother provided a timeline of the incident, beginning the day prior. On 12/10/23, following a bath around 11:30AM, the mother fed the child 2oz of formula, which he spit up. The child was then placed in his play pen, which was observed to be free of clutter and in the living room, and napped from 1:30PM to 5:30PM. At that time, the child woke up and cried, which was his hunger cue, so the mother fed the child another 2oz of formula. The mother fed the child every 30 minutes until 7:30PM because the child was crying. The family was watching a movie together in the living room and the child was "dozing off." Around 9-9:30PM, the child cried again, the mother fed him another 2oz, and placed him on top of the mother's twin-sized mattress. The mother re-arranged the bedding for ACS to depict how the bed was made the night of the incident and the bed included two pillows at the headboard, a comforter overtop the pillows, another comforter placed in a disorganized fashion on the lefthand side of the mattress, an additional pillow placed in such a way to prevent the child from rolling over into a gap between the mattress and wall, and the child was placed next to that pillow, on his left side, facing the pillow. The mother affirmed she was aware of safe sleep recommendations; however, since the child cried when placed in the crib, they co-slept every evening this way, with the child on his left side and the mother on her right side. After the movie ended around 10:00PM, the mother, sibling, and grandmother went to sleep. The child woke throughout the night for feeding at 1:45AM, 3:45AM, and 7:00AM; however, did not take the bottle at the 7:00AM feeding. The mother went back to sleep and when she awoke at 9:00AM and tried to wake the child, he was unresponsive.

The grandmother had been visiting the home since the child's birth. When the mother called for assistance, she went to the mother's room and saw the mother holding the child. The grandmother took the child from the mother, told the mother to call 911 because the child's lips were blue, and the grandmother started CPR by giving chest compressions and mouth to mouth. The grandmother reported no prior concerns for the mother. The sibling was at school at the time of the incident.

ACS interviewed the child's father via telephone and learned the father did not reside with the child and had received a call from the mother the morning of the fatal incident. The father proceeded to go to the mother's home and arrived about 9:30AM and the child was being brought to the hospital at that time. The father reported being "active" in the child's life and saw him almost daily at the mother's house. The father had last seen the child on 12/9/23 and voiced no concerns for the mother's care of the child.

ACS contacted numerous collaterals, including the pediatrician, hospital staff, law enforcement, the ME, the sibling's school, and the mother's mental health provider. The pediatrician reported having seen the child once, as the child was only two months old. A referral had been given for a cardiologist appointment, scheduled for 12/11/23. The pediatrician stated the referral was due to an incomplete fetal echocardiogram. It was unknown if there were specific cardiac concerns for the child.

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
066484 - Deceased Child, Male, 2 Month(s)	066485 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
066484 - Deceased Child, Male, 2 Month(s)	066485 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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:
Bereavement services were offered to the sibling by his school and ACS; however, the sibling denied needing services at that time. ACS requested that the mother's mental health provider, who was researching bereavement groups, also look for a group relevant to the sibling. At the close of the investigation, the sibling was not engaged in counseling services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother had a previously established mental health provider, whom she continued to utilize following the fatality. ACS confirmed bereavement work was being done with the mother. The mother was actively engaged in counseling services at the close of the investigation. ACS provided burial assistance to the mother as well, which the mother utilized.

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

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
- [x] 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
- [x] 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 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