Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-121

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

Issue Date: Apr 22, 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: 13 day(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 12/14/2023
Initial Date OCFS Notified: 12/14/2023

Presenting Information

An SCR report was received on 12/14/23, which alleged at approximately 8:17AM, the subject mother found the 2-week-old subject child unresponsive and not breathing in his crib. The subject mother called 911 and the subject child was brought to the hospital by ambulance. Emergency medical services and hospital personnel attempted to revive the child but were unsuccessful. The subject child was pronounced deceased at the hospital. The cause of death was unknown. The subject child was otherwise healthy before he passed away and the subject mother had no explanation for his death.

Executive Summary

This report concerns the death of a 2-week-old male child that occurred on 12/14/23. The Administration for Children's Services (ACS) received an SCR report on that same date, regarding the fatality. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother. At the time of his death, the subject child resided with his mother at a local shelter. The father did not reside in the home but resided locally and was not present during the fatal incident. ACS immediately initiated their investigation and determined there were no surviving siblings.

Through a joint investigation with law enforcement, it was learned on 12/13/23, at approximately 10:00PM, the mother fed the child and put him down to sleep in his bassinet. On 12/14/23, at approximately 4:00AM, the mother fed the child again and they both went back to sleep. It was unclear if the mother put the child back into the bassinet. At 7:00AM, the mother awoke to feed the subject child and noticed he was unresponsive. The mother contacted 911, law enforcement and emergency medical services arrived and attempted life-saving efforts. The subject child was transported to the hospital where life-saving efforts were continued; however, were unsuccessful. The subject child was pronounced deceased shortly after arrival at 8:13AM.

ACS communicated with the medical examiner's office and learned a preliminary autopsy was completed and showed there were no signs of natural disease or trauma. Additionally, the subject child was normally developed and well nourished. ACS inquired if safe sleep could have contributed to the child's death but was told that information would be in the final report. At the time this report was written, the autopsy report was pending further studies. ACS communicated with law enforcement and learned there were no criminal charges pending against the mother and it appeared the criminal investigation was on-going.

ACS unsubstantiated the above referenced allegations against the mother stating that they did not find a fair preponderance of evidence. ACS determined their investigation based on information that was obtained; however, interviews with the mother and father were lacking information regarding the incident. The record was unclear where the child was sleeping when the mother woke at 7:00AM. It was unclear how ACS determined their investigation without gathering such information as to where the child was sleeping. ACS gathered information from collateral contacts such as, shelter staff, law enforcement and the medical examiner's office; however, lacked correspondence with emergency medical officials who responded to the fatality and the child's pediatrician. Progress notes were entered contemporaneously, and the required notice of existence letters were mailed to the mother and father.

ACS offered the mother bereavement services; however, did not discuss said service with the father. In addition, burial assistance was offered to the mother a month after the fatality, but the mother had already made arrangements for the child's services. It was unclear if the mother accepted either service.

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:**
  - **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 investigation?** Unable to determine - insufficient documentation.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
ACS made the decision to unsubstantiate the allegations based on evidence obtained throughout their investigation; however, interviews with the mother and father were lacking key information regarding the incident. At the time this report was written, the writer was unable to determine if unsubstantiating the allegations was appropriate.

Was the decision to close the case appropriate? Unknown

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. Interviews with the mother and father were lacking information regarding the incident. In addition, the mother requested additional services which were not provided to her, and the father was not offered any services.

Required Actions Related to the Fatality

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

Issue:	Failure to Offer Appropriate Services
Summary:	The father was not offered any services and the mother asked ACS for any additional services available, but there was no conversation documented exploring any other needs the mother may have had.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	When service needs are identified, ACS will make the appropriate referral to Preventive Services in an effort to determine whether there are services that can benefit the family.

Issue:	Overall Completeness and Adequacy of Investigations
Summary:	Interviews with the mother and father lacked sufficient details surrounding the fatality. The interviews were brief and did not gather enough information regarding the incident. In addition, neither parent was interviewed face-to-face.
Legal Reference:	SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:	ACS will make face-to-face contacts with child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/14/2023 **Time of Death:** 08:13 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: 07:36 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
Deceased Child's Household	Deceased Child	Alleged Victim	Male	13 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Father	No Role	Male	27 Year(s)

LDSS Response

On 12/14/23, ACS received a report regarding the death of the subject child. ACS initiated their investigation within 24 hours, notified the DA, ME and coordinated their efforts with LE. ACS contacted the source of the report, completed a

CPS history check, and learned there were no surviving siblings.

ACS completed an interview with the father on 12/15/23. During his interview, he explained he last saw the subject child on 12/13/23. The father reported on that same date, he had picked up the mother and child and took them out to eat. He then brought them back to the shelter and denied going inside.

ACS completed an interview with the mother on 12/19/23. During her interview, she described the day on 12/13/23, as normal and explained she went to the store and took the subject child for a walk. In the evening, she reported the child was crying more than usual and she fed him at 10:00PM. After the feeding, she burped the child, held him, made skin to skin contact, and then placed him into his bassinet. After the child feel asleep, the mother then went to sleep. Around 4:00AM, the subject child began crying and woke the mother who then fed, burped, changed the child's diaper, and made skin to skin contact again. The mother put the child back to sleep and woke again at 7:00AM. The mother thought that the child was still asleep at that time and changed his diaper and then attempted face stimulating techniques which she stated did not work. The mother described that the child's mouth was open, and after waiting five minutes for him to respond to her above attempts to wake the child she started CPR. The mother explained she did not know what she was doing when she attempted CPR. The mother then contacted 911 who gave instructions on how to preform CPR and then LE arrived.

ACS communicated with LE officers who responded to the mother's home after she contacted 911. LE spoke with the mother regarding the incident and she was consistent with her explanation to ACS. LE explained upon arrival, the mother answered the door and immediately led them to the child's bassinet where he was observed to be laying on his back, face up, wearing only a diaper, and with a sheet underneath him in the bassinet. LE observed the child was unresponsive and immediately initiated CPR. EMS arrived shortly after and took over life-saving efforts while transporting the child to the hospital. LE reported the room was very small and cluttered with provisions for the child and food containers. In addition, an aroma of marijuana was detected in the room and marijuana was found in the bathroom. The mother reported to LE the child was born underweight and spent two days in the NICU.

ACS spoke with the mother on 1/11/24 and discussed concerns relating to her marijuana use. The mother denied consuming any substances during her pregnancy. The mother reported smoking marijuana three times a week and denied smoking in the presence of the subject child.

ACS made numerous attempts to speak with the physician who pronounced the subject child deceased and any staff that were involved in the child's care while at the hospital; however, were unsuccessful.

ACS communicated with shelter staff who reported on the day of the incident, they were unaware anything had occurred until LE and the ambulance arrived. There were no other individuals observed entering or leaving the building with the mother. Shelter staff reported the mother was observed to look out of it and shocked when she left. The mother entered the shelter 6 months prior when she was pregnant.

ACS offered the mother supportive services, and it was unclear if the mother accepted. There were no surviving siblings, and the investigation was closed on 2/12/24.

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
066430 - Deceased Child, Male, 13 Day(s)	066431 - Mother, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
066430 - Deceased Child, Male, 13 Day(s)	066431 - Mother, Female, 22 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:
ACS made attempts to speak with emergency room personnel; however, were unsuccessful. The record reflected ACS did not make attempts to communicate with EMS or the child's pediatrician.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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:
Bereavement services were offered to the subject mother but not the father. Funeral arrangements were offered after the services were taken care of.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No

Explain:
The subject mother was offered bereavement services, but the father was not. The subject mother was offered burial assistance about a month after the subject child's death, and the services had already been planned. It was unclear if the mother accepted either service.

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
- ☐ 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 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