Child Fatality Report

Report Identification Number: NY-23-123

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

Issue Date: May 13, 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: 3 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 12/15/2023
Initial Date OCFS Notified: 12/15/2023

Presenting Information

The SCR report alleged that on more than one occasion, the father shook the 3-month-old subject child. As a result, for three days, the subject child threw up 2 to 2 1/2 ounces of liquid. On 12/4/23, the subject child was lying with one eye open and gasping for air. The father notified the mother who came home and sought medical services for the subject child. The mother arrived at the medical facility at approximately 1:04 AM, and the subject child was in respiratory distress at that time. The subject child was diagnosed with a Subarachnoid Hemorrhage on the right occipital bone and left subdural and placed on life support. The subject child remained in a medical facility until 12/15/23 when she was pronounced deceased following a second brain death test. The subject child's death was the direct result of the father shaking her.

Executive Summary

This fatality report concerns the death of the 3-month-old female subject child that occurred on 12/15/23. An initial report was received regarding the fatal incident on 12/4/23. The SCR report included allegations of Choking/Twisting/Shaking, Internal Injuries, Inadequate Guardianship, and DOA/Fatality against the father. At the time of her death, the subject child resided with her mother and father. There were no surviving siblings or children in the household.

The Administration for Children's Services (ACS) completed casework and collateral activity and learned that on 12/3/23, the subject child was in the care of the father while the mother was at work. At an unknown time, the father went to feed the subject child and stated her arm was shaking, she appeared lethargic and had labored breathing. The father called 911 and emergency medical services responded. The subject child was given oxygen and transported to the hospital. Upon evaluation, the subject child was found to have multiple brain bleeds, a rib fracture, retinal hemorrhages, and a skull fracture. The subject child was transferred to a different hospital for a higher level of care where she was diagnosed with abusive head trauma and noted to have non-accidental injuries indicative of shaken baby syndrome. The subject child remained hospitalized until 12/15/23 when she succumbed to her injuries.

An autopsy was performed, and the final cause and manner of death were pending further studies. The medical examiner noted there was a high suspicion of inflicted injuries to the subject child. There were no marks or bruises noted on the subject child. The law enforcement investigation remained open pending the final autopsy. No arrests had been made related to the subject child's death at the time the CPS investigation closed.

Bereavement services were offered to the parents and burial assistance to the mother. It was unknown if services were utilized. The mother stated she had familial support. The 24-hour Fatality Report was completed late on 12/18/24. The allegations against the father were substantiated due to the subject child's non-accidental injuries. The CPS investigation was indicated and closed on 2/7/24.

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:**
  - **Safety assessment due at the time of determination?** 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:
ACS made an appropriate determination based on evidence obtained during the investigation.

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. The 24-Hour Fatality Report was completed late on 12/18/23.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-hour Fatality Report was completed late on 12/18/23.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/15/2023 **Time of Death:** 02:57 PM

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: 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	21 Year(s)
Deceased Child's Household	Mother	No Role	Female	19 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their efforts with LE, notified the DA's office, interviewed the SF and BM, and contacted collateral sources.

The SF was initially interviewed by LE and reported that on 12/3/23, he went to feed the SC and the SC's arm was shaking, she was lethargic and had labored breathing. The SF reported called 911 and that EMS responded. The SC was provided oxygen and transported to the hospital. In his interview with ACS, the SF denied knowing how the SC was injured and denied dropping or shaking the SC. The SF stated the SC was happy, ate, and slept fine on the day of the fatal incident. The SF stated later that day he noticed the SC was making gasping noises. The BM was interviewed and reported the SF called her while she was at work to inform her the SC was having problems breathing and had one eye open and one eye closed. The BM advised the SF to get the SC to the hospital. The SF stated he was going to take the bus, but the BM advised him to call 911. The SF later reported in a subsequent interview with LE that he dropped the SC on 12/3/23 before contacting 911.

The SF reported that the SC rolled off the bed on an unknown date in November 2023, when he was feeding the SC, placed her on the edge of the bed, and reached for the SC's bottle. The SF stated the SC rolled off the bed; however, the BM reported that SC could hold her neck up and look around but was unable to roll over. The SF told the BM about the fall; however, the BM stated she thought the SF was kidding as the SC did not roll. Medical staff stated the injuries the SC sustained were acute and were not consistent with a fall from a bed in November or being dropped and were instead indicative of shaken baby syndrome.

The BM reported the SC appeared more "fretful" when being held by the SF in the week leading up to her death, but thought the SC just had a preference.

The parents reported the SC had been vomiting frequently in the weeks preceding her death. The parents reported the SC was seen medically on 11/20/23, 11/25/23, and 12/1/23 due to the vomiting and being congested. This was confirmed through medical records, which indicated the SC had been diagnosed with rhinovirus and unspecified vomiting. The SC was discharged each visit and the BM reported an ultrasound was completed that revealed no concerns. The SC was being monitored by her pediatrician for weight checks.

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
066808 - Deceased Child, Female, 3 Month(s)	066810 - Father, Male, 21 Year(s)	Choking / Twisting / Shaking	Substantiated
066808 - Deceased Child, Female, 3 Month(s)	066810 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
066808 - Deceased Child, Female, 3 Month(s)	066810 - Father, Male, 21 Year(s)	Internal Injuries	Substantiated
066808 - Deceased Child, Female, 3 Month(s)	066810 - Father, Male, 21 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?	☐	☒	☐	☐

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 and burial assistance were offered; however, it was unknown if they were utilized.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The parents were offered bereavement services; however, it was unknown if services were utilized. The SM reported that she had been connected to grief counseling through the hospital but did not feel it was necessary, and had familial support. ACS offered burial assistance, though it was unknown if it was used.

History Prior to the Fatality

Child Information

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/04/2023	Deceased Child, Female, 2 Months	Father, Male, 21 Years	Choking / Twisting / Shaking	Substantiated	No
	Deceased Child, Female, 2 Months	Father, Male, 21 Years	Fractures	Substantiated	
	Deceased Child, Female, 2 Months	Father, Male, 21 Years	Inadequate Guardianship	Substantiated	

Deceased Child, Female, 2 Months	Father, Male, 21 Years	Internal Injuries	Substantiated
Deceased Child, Female, 2 Months	Mother, Female, 19 Years	Fractures	Unsubstantiated
Deceased Child, Female, 2 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 2 Months	Mother, Female, 19 Years	Internal Injuries	Unsubstantiated
Deceased Child, Female, 2 Months	Mother, Female, 19 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
The SCR report alleged the SC fell off the bed in November of 2023 while in the care of the BM. The BM was aware of the fall but did not bring the SC to receive medical treatment. On 12/4/23, after further medical treatments were conducted, it was discovered that the SC had three brain bleeds and a skull fracture.

Report Determination: Indicated | **Date of Determination:** 02/02/2024

Basis for Determination:
ACS substantiated the allegations against the SF and unsubstantiated the allegations against the BM. The SF was the primary caregiver for the SC while the BM worked. The SF reported on 12/3/23 the SC woke up from a nap, was breathing funny, and gasping for air. The SC was brought to the hospital and intubated. The SC's injuries were indicative of non-accidental trauma and the SC was diagnosed with abusive head trauma. The SC had brain bleeding and swelling, retinal hemorrhages, and loss of white brain matter. The SC succumbed to her injuries on 12/15/23. The SF initially reported the SC fell off the bed in November 2023, but later reported to LE that he dropped the SC on 12/3/23.

OCFS Review Results:
ACS initiated their investigation within 24 hours, coordinated efforts with LE, interviewed the BM and SF, and contacted collateral sources. ACS completed documentation timely and accurately.

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

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