Report Identification Number: NY-23-132

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 **Jurisdiction:** Queens **Date of Death:** 12/31/2023
Age: 8 month(s) **Gender:** Male **Initial Date OCFS Notified:** 12/31/2023

Presenting Information

An SCR report received on 12/31/23 alleged that on 12/30/23, the subject child was put to bed by one of the parents at an unknown time. On 12/31/23, at approximately 5:00AM, one of the parents checked on the child and found him unresponsive. The parents called 911 and the mother initiated cardiopulmonary resuscitation (CPR). Emergency medical services (EMS) arrived and continued CPR and transported the child to the hospital. The child was unable to be resuscitated and was pronounced deceased at 6:26AM. The child was an otherwise healthy child, and the parents had no explanation for his death. Two additional reports were received on 2/20/24 and 2/21/24 which alleged that at some point while in the care of the parents, the child ingested cocaine as the child's toxicology was positive for cocaine at the time of his death.

Executive Summary

This report concerns the death of the 8-month-old subject child. The Administration for Children's Services (ACS) received three SCR reports regarding the child's death. The investigation was prompted upon the receipt of the initial report on 12/31/23. At the time of the child's death, he resided with his mother, father, siblings (ages 7 and 4), maternal grandmother, and maternal great-grandfather.

On the evening of 12/30/23, the family was home watching movies. There was no school, so the family stayed up late. The mother fed the subject child around 3:00AM, while singing him a lullaby. The child appeared well and content and was falling asleep in the mother's arms. The mother was laying with her head leaning against the bedframe and next recalled waking at 5:00AM and seeing the child "in a crawling position" on the bed. When the mother picked the child up, he did not respond. Panicked, the mother woke the father and screamed. The grandmother came into the room, and someone also called the maternal cousin who lived nearby. The mother performed CPR, but the child did not respond. The maternal cousin also attempted CPR to no avail. 911 was called at 5:32AM and EMS transported the child to the hospital. The child was in cardiac arrest upon arrival and pronounced deceased at 6:26AM.

The medical examiner was notified and performed an autopsy of the child. The cause and manner of death were pending; however, toxicology results indicated the presence of cocaine in the child's system. Law enforcement was aware of the positive toxicology and their investigation remained ongoing.

Upon learning of the positive toxicology, the siblings were removed and placed in the care of a relative resource. Petitions were filed in Family Court and a subsequent Family Services Stage (FSS) was opened for ongoing services and monitoring. The parents were permitted supervised visitation. The mother was re-interviewed and denied any use or sale of cocaine by herself or the father. The father did not cooperate with interview attempts.

ACS substantiated the allegations against the parents regarding the subject child. The Investigation Conclusion Narrative stated, for all three allegations of Inadequate Guardianship, DOA/Fatality, and Poisoning/Noxious Substance, that the child's toxicology revealed the child had cocaine in his system. Although assessed to be in immediate/impending danger and removed from the parents' care, no allegations were added regarding the siblings. Progress notes reflected the medical examiner relayed to law enforcement that the cocaine found in the child's system may have caused the child's immediate death.

The mother declined bereavement services offered by ACS.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? N/A

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:

An FSS was opened on 2/20/24, following a subsequent SCR report. The CPS investigation was indicated and closed on 3/13/24 and the FSS remained open as the siblings' continued in the care of a relative and Family Court proceedings were ongoing.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The mother was interviewed about allegations only. There were no full interviews of the siblings to assess overall safety and risk.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make face-to-face contacts with a child and/or a 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.
Issue:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	ACS determined the siblings were in immediate/impending danger, filed in Family Court, and executed a removal; however, no allegations against the parents regarding the siblings were added/substantiated.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	ACS will appropriately add and determine allegations regarding the nature, extent and cause of any condition enumerated in such report and any other condition that may constitute abuse or maltreatment.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The Safety Assessments inconsistently recorded DV as a safety factor, at times indicating its presence placed the siblings in immediate/impending danger, yet there was no recent history of DV and progress notes reflected no DV concerns.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.
Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	Progress notes reflected the siblings were removed; however, their program choice did not reflect placement, which affected the accuracy of the FASP, and the Activities window did not reflect a removal.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual, and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/31/2023 **Time of Death:** 06:26 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: 05:32 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Yes
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	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	63 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	98 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)

LDSS Response

ACS initiated their investigation upon receipt of the initial SCR report received on 12/31/23 regarding the child’s death and coordinated their response with law enforcement. ACS contacted the source, completed a CPS history check regarding the family and learned there was no child protective history, and informed the DA of the fatality. The father was combative with law enforcement and denied ACS access to the home initially. A home visit was able to be completed with the mother on 1/3/24 and the siblings were assessed as safe at that time.

The mother was interviewed about the night of the fatal event. The mother reported the family had been up late watching movies because there was no school. Around 3:00AM in the early morning of 12/31/23, the mother fed the child a bottle. After finishing the bottle, the mother did not put the child back in his crib, which was his usual sleeping space. The mother confirmed she was aware of safe sleep recommendations and the dangers of co-sleeping, but on that night, she did not place the child back to sleep in the crib, and seemingly fell asleep with the child in her arms. The mother woke around 5:00AM and found the child on the mattress, which was queen-sized and shared between the mother and father. The medical legal investigator reported the child was found face-down. The mother and maternal cousin attempted CPR and 911 was called. Upon learning of the child’s positive toxicology, the mother was re-interviewed and denied any knowledge of knowing about the toxicology or why it was positive for cocaine. The mother denied drug use or sales for herself and the father and stated she would take a drug test. Drug tests were twice scheduled for the mother and were not completed.

The father did not cooperate with interviews and the siblings were not interviewed. Relatives close to the family denied concerns of drug use and all reported no concerns regarding the parents. Law enforcement records did reflect a drug-related arrest history for the father in 2016, 2007, and 2006.

ACS spoke with the medical examiner, who confirmed the presence of cocaine in the child’s heart blood, chest cavity, and eyes. Other testing remained pending. When asked if the quantity of cocaine caused the child to go into cardiac arrest, the medical examiner reported the body’s response to cocaine would trigger arrythmia (irregular heartbeat). The medical

examiner stated the levels found would cause an adult to feel intoxicated. The examiner was unable to say if the cocaine was ingested or inhaled, but given the child's age, felt it would not have been inhaled and stated it could have been ingested through food supply, or the child touching a contaminated surface.

Family Court proceedings were initiated on 2/21/24. The parents requested communication go through attorneys and exercised their right to a 1028 hearing.

ACS contacted the siblings' schools, who reported no concerns. The siblings' pediatrician noted them to be up to date. The subject child's pediatric records were requested but not received. The siblings remained in the care of a relative resource and were assessed safe with that resource at the time the CPS investigation was indicated and closed.

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
066838 - Deceased Child, Male, 8 Month(s)	066841 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated
066838 - Deceased Child, Male, 8 Month(s)	066841 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
066838 - Deceased Child, Male, 8 Month(s)	066841 - Mother, Female, 36 Year(s)	Poisoning / Noxious Substances	Substantiated
066838 - Deceased Child, Male, 8 Month(s)	066842 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
066838 - Deceased Child, Male, 8 Month(s)	066842 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
066838 - Deceased Child, Male, 8 Month(s)	066842 - Father, Male, 34 Year(s)	Poisoning / Noxious Substances	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	☐	☒	☐	☐
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?	☒	☐	☐	☐

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
A removal of the siblings was conducted on 2/21/24 once the subject child's toxicology came back positive for cocaine with neither parent offering an explanation as to how the child ingested or came in contact with the substance.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/21/2024	There was not a fact finding	There was not a disposition
Respondent:	066841 Mother Female 36 Year(s)	
Comments:	An Article 10 Abuse Petition was filed against the mother and father in Family Court on 2/21/24. The siblings were removed and placed with a relative resource. The resource did not wish to become a foster parent to the siblings, but was willing to be a long-term resource if needed. The record did not reflect if the siblings' placement was pursuant to FCA 1017 due to the relative not pursuing foster care certification. The parents filed an Application to Return Child Temporarily Removed (1028) and court proceedings were ongoing when the CPS investigation was closed. The subsequent Family Services Stage remained open. It was not documented if the parents were ordered by the court to participate in any services.	

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:
The mother was scheduled for two drug screens, which she did not complete. The father documented refusal due to religious reasons. It was unknown if either parent was referred for a substance use evaluation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother was provided bereavement resources; however, the family indicated they would use their faith-based resources and declined referrals from ACS. The mother requested burial assistance, it was unknown if this was provided.

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
☒ 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 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