Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-001

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

Issue Date: Jun 05, 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: 4 month(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 01/05/2024
Initial Date OCFS Notified: 01/05/2024

Presenting Information

On 1/5/2024, the New York City Administration for Children's Services (ACS) received initial and duplicate SCR reports regarding the death of the 4-month-old subject child which occurred that day. Around 2:30 PM, the father fed the subject child and laid down for a nap with the subject child in the adult bed. Around 3:30 PM, the father woke and found the subject child unresponsive and blue. The father wrapped the subject child in a blanket and took the child to the hospital for medical assistance, arriving at 3:55 PM. Life-saving measures were unsuccessful and the subject child was pronounced deceased.

Executive Summary

This report concerns the death of a 4-month-old subject child which occurred on 1/5/2024. At the time of his death, the subject child resided with his mother and father. There were no surviving siblings or other children in the household.

On 1/5/2024, the mother left the home to go to work between 9:00 AM and 10:00 AM. The father stayed home to care for the subject child. The father fed the subject child formula around 3:00 PM, burped the child, and placed the child down to sleep on his back in the parents' adult bed. The subject child was placed to sleep between the father and an approximately five-foot-long stuffed animal toy. The subject child was covered to his chest with a baby blanket and another blanket. The father fell asleep in the bed next to the subject child and woke about 30 minutes later. When he awoke, the father noticed the subject child was unresponsive, limp, warm, and pale. The father attempted to perform CPR and the subject child did not respond. The father requested transportation through a ride-sharing application at 3:52 PM and the car arrived at 3:58 PM to transport the father and subject child to the hospital.

Hospital staff reported the father and subject child arrived at the hospital at 4:05 PM and the subject child was blue in color and unresponsive upon arrival. Hospital staff initiated life saving measures; however, the subject child was pronounced deceased at 4:25 PM.

ACS spoke with the Medical Examiner and learned that an autopsy was performed; however, the final autopsy report and death certificate were not available, pending laboratory testing. The Medical Examiner reported there were no injuries observed during the autopsy and no abuse was suspected, but the subject child's lungs were "slightly heavy" which could be indicative of a viral infection. The record reflected the Medical Examiner was not asked about the unsafe sleep environment. Law enforcement reported the criminal investigation was closed with no charges or arrests; however, the investigation could be re-opened if the pending autopsy report and death certificate showed evidence of abuse.

The allegations of Inadequate Guardianship and DOA / Fatality were unsubstantiated against the father. The Investigation Conclusion Narrative noted there was a lack of evidence to support the allegations and the death certificate and final autopsy report were not yet available.

The record reflected the mother and father placed the subject child in imminent danger of harm by routinely co-sleeping with the subject child in the adult bed along with blankets, pillows, and stuffed toys. As such, the allegation of Inadequate Guardianship should have been added against the mother and substantiated against both parents.

A copy of the final autopsy report was made available to OCFS after the closure of the CPS investigation. The cause of death was noted to be "Sudden Unexplained Infant Death with intrinsic and extrinsic factors" and the manner of death was

noted to be "Undetermined (bed sharing)." The intrinsic factors were listed as: Respiratory Viral Bronchitis, positive nasal swabs for Coronavirus and Rhinovirus, and microscopic features suggestive of Hippocampal Dysgenesis and the extrinsic factor was listed as "bed sharing with adult in adult bed."

ACS provided the mother and father with referrals for bereavement services. ACS offered the family burial assistance; however, the family declined the 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 actions the ACS has taken, or will take, to address the cited issues. 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?** No

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:

ACS initiated a timely investigation, visited the hospital and home, conducted interviews with the parents, and gathered information from pertinent collaterals. The record reflected a fair preponderance of evidence gathered to substantiate the allegation of Inadequate Guardianship against both parents; however, the allegations were unsubstantiated.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegation of Inadequate Guardianship was incorrectly unsubstantiated. The father routinely placed the subject child at risk of harm when co-sleeping in the adult bed with multiple blankets and a 5-foot-tall stuffed toy.
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 New York City Regional Office if further guidance is needed.
Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	The record reflected the allegation of Inadequate Guardianship should have been added and substantiated against the mother. Furthermore, medical professionals were not asked pertinent questions regarding the unsafe sleep environment.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/05/2024 **Time of Death:** 04:25 PM

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

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)

LDSS Response

ACS initiated an investigation immediately upon receipt of the SCR report. ACS conducted interviews with the mother and father, visited the home, and gathered information from pertinent sources such as law enforcement, hospital staff, the Medical Examiner, and the subject child's pediatrician.

The mother and father were interviewed separately and provided similar information regarding the events leading to the death of the subject child. Both parents stated the subject child was healthy and appeared well in the days prior to his death. The parents also reported it was their common practice to co-sleep with the subject child between them in a queen size bed. On the day of the subject child's death, the mother breastfed the subject child just before leaving to go to work between 9:00 AM and 10:00 AM. The father stayed home with the subject child. The father fed the subject child formula around 3:00 PM and then placed the subject child down to sleep in the adult bed, next to a large stuffed toy. The father got into the bed to take a nap with the subject child and pulled a blanket onto himself and the subject child. About 30 minutes later, the father woke and found the subject child was unresponsive, limp, and pale. The father attempted to perform CPR, having learned it from watching a video. When the subject child did not respond, the father requested a car through a ride-sharing service. The father reported he did not call 911 as he believed the ambulance would take too long. The car arrived and the father got in with the subject child and traveled to the hospital, where the subject child was pronounced deceased.

Through contact with hospital staff, ACS learned the subject child had been treated in the hospital in December of 2023 after he was accidentally dropped by the maternal grandmother. The subject child was monitored and released home the same day with no concerns. In speaking with the Medical Examiner, ACS learned it was unlikely the fall would have contributed to the subject child's death.

Through contact with the subject child's pediatrician, ACS learned the subject child was seen for most well-visits but was behind on his immunizations due to missed appointments. The pediatrician reported no concerns for the subject child in the care of the mother and father.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical cause
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: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
067288 - Deceased Child, Male, 4 Month(s)	067290 - Father, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated
067288 - Deceased Child, Male, 4 Month(s)	067290 - Father, Male, 21 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?	☒	☐	☐	☐
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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided the mother and father with referrals for bereavement counseling. The mother and father declined burial assistance.

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 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