Child Fatality Report

Report Identification Number: NY-24-016

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

Issue Date: Jun 10, 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: 1 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 03/08/2024
Initial Date OCFS Notified: 03/08/2024

Presenting Information

An SCR report was received on 3/8/24, alleging on the same day, the SM laid the SC on his back in her bed and placed a pillow under his head. When the SM returned, she found the SC had turned over and was face down on the bed, not breathing. The SM called 911. The SC was pronounced dead at 9:24AM. The unsafe sleep arrangement contributed to the death of the SC.

Executive Summary

The New York City Administration for Children's Services (ACS) received an SCR report on 3/8/24, regarding the death of the 1-month-old male subject child. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the subject mother regarding the subject child. At the time of his death, the subject child resided with his mother, father, paternal aunt, paternal uncle, and 11-year-old surviving cousin. ACS immediately assessed the safety of the surviving cousin and determined she was safe in the care of her parents. The father reported having another child who resided outside of the country and ACS did not make contact with this child.

ACS learned the subject mother breastfed the subject child and then left him on his back on her bed while she went to the bathroom and into the kitchen for 5 to 10 minutes. The subject mother described the subject child as having a big, cotton pillow under his head and a blanket covering him. The subject mother returned and found the subject child face down on his stomach. When the subject mother flipped the subject child over, there was a clear liquid coming from his mouth and his face was a red, pale color. The subject mother attempted to contact 911 but instead was dialing 991. The subject mother contacted her midwife who was able to direct the subject mother to call 911. EMS arrived on scene and attempted life-saving measures. The subject child was transported to the hospital where he was pronounced deceased. The father left for work that morning around 6:40AM and the subject child was awake. Both parents reported no one else in the home had contact with the subject child in the 24 hours prior to the fatal incident.

ACS remained in consistent contact with the medical examiner's office. An autopsy was completed; however, the results were pending. The medical examiner reported the death appeared to be natural, no foul play was suspected, and the subject child did not have any signs of abuse or neglect. The medical examiner stated the possible cause of death was sudden infant death syndrome; however, could not give a final cause of death until the toxicology results were received. Law enforcement reported the incident was ruled as accidental because the autopsy revealed no foul play. Law enforcement was waiting for a signature from the medical examiner and the death certificate to close their investigation.

ACS provided the family with resources for bereavement counseling and coordinated contact with funeral homes to assist the family with receiving funeral assistance. ACS appropriately substantiated the allegation of Inadequate Guardianship against the subject mother regarding the subject child due to the subject mother reportedly leaving the subject child in an unsafe sleep position unattended, and appropriately unsubstantiated the allegation of DOA/Fatality against the subject mother regarding the subject child.

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

Explain:
Sufficient information was gathered to make the determination regarding the allegations.

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 because ACS did not add all of the household members to the investigation. The record was inconsistent, as there was a minor cousin living in the home, though ACS documented there were no surviving children.

Required Actions Related to the Fatality

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

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	ACS learned the family was residing with a PA, PU and cousin; however, their information and demographics were never added in CONNECTIONS; therefore, pertinent information was inaccurately recorded in the case record of this investigation.
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.

Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	ACS briefly spoke with the surviving cousin regarding the allegations concerns; however, did not complete a comprehensive interview to determine if there were any safety or risk factors present regarding the surviving cousin.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/08/2024 **Time of Death:** 09:24 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: 08:56 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	Aunt/Uncle	No Role	Female	31 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	31 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	No Role	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	11 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS initiated their investigation within 24 hours and coordinated their efforts with LE. ACS contacted the source of the report, reviewed prior CPS history, and notified the DA and ME of the death. ACS immediately assessed the 11yo surviving cousin to be safe in the care of her parents.

The night prior to the incident, the SM breastfed the SC and put him to sleep in his crib, then breastfed him again at 4:00AM and placed him back in his crib. The SM reported, around 6:40AM, the SC woke up and she placed him in bed with the BF while she made breakfast; however, the BF reported he left the home around 6:40AM. The SM breastfed the SC from 7:30AM until 8:00AM, then left him on his back, on her bed and left the room. When she returned, the SC was on his stomach and unresponsive. When the SM was able to reach 911, they instructed her to perform CPR until EMS arrived and took over. The SM reported the SC was able to hold his head up and roll over. The SM reported when she gave birth to the SC, the hospital discussed safe sleep with her, and the SM was aware of safe sleep guidelines. The SM reported she did not follow safe sleep protocol that day due to having to use the bathroom badly, being tired, and having difficulty getting the SC to unlatch from her breast. The BF was at work when the fatal incident occurred and had nothing further to add. The BF confirmed he received the same safe sleep education at the hospital as the SM, and was aware of safe sleep guidelines.

The SM performed a reenactment of the incident. She demonstrated how she laid the SC on the bed, showed the clothes he was wearing, and how she found him. The SC had a big, cotton pillow under his head and he was covered with a blanket. Next to the queen-size bed there was a crib with a makeshift hammock above it where the SC slept.

ACS spoke with the PA, PU and the 11yo surviving cousin separately. They all reported they rarely saw the SM, SC or the BF. They denied ever caring for the SC, denied having contact with the SC 24 hours prior to the fatal incident, and denied having concerns for the care of the SC.

ACS spoke with the physician at the hospital. The SC arrived at the hospital via EMS at 9:15AM. The SC had no heart rate or vitals. CPR was performed until the SC was pronounced deceased at 9:24AM. The physician reported the SC could not have rolled onto his stomach due to his age. ACS spoke with the primary care provider who saw the SC for a newborn exam on 2/16/24 and there were no concerns at that time. The primary care provider confirmed educating the SM on safe sleep at the newborn exam. The primary care provider reported the SC would not have been able to roll over due to his age. ACS spoke with the midwife who confirmed the SM called her during the incident and she told the SM to call 911. The midwife also reported she had discussed safe sleep protocol with the parents.

ACS spoke with the LE officer that responded to the scene. The 911 call was received at 8:56AM. When the officer arrived at the home the fire department was already there performing CPR. The information the officer received from the SM was that she breastfed the SC from 7:00 to 8:20AM and when the SC was asleep, she placed him on his back and went to the bathroom.

ACS interviewed the family, assessed the home and the surviving cousin to be safe, provided resources, entered notes contemporaneously, and contacted collaterals. ACS did not add the PA, PU or the surviving cousin to the case and documented in the notes and Safety Assessments there were no surviving children. ACS was directed to contact the surviving half-sibling residing outside of the country; however, ACS did not follow up with the BF to get the contact information. The family members were interviewed regarding the fatal incident; however, ACS did not compete full comprehensive interviews to determine if there were risk concerns for the surviving cousin.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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
067308 - Deceased Child, Male, 1 Month(s)	067309 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
067308 - Deceased Child, Male, 1 Month(s)	067309 - Mother, Female, 24 Year(s)	Inadequate Guardianship	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	☐	☒	☐	☐
School	☐	☒	☐	☐
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 spoke with the responding officer; however, did not attempt to contact EMS or attempt to speak with the surviving cousins primary care provider or school.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The parents were provided with resources for bereavement counseling and funeral assistance.

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:
A surviving cousin resided in the deceased child's home; however, she was not added to the investigation and was not provided with resources.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were provided with resources for bereavement counseling and funeral services.

History Prior to the Fatality

Child Fatality Report

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.

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