



x

Report Identification Number: NY-22-071

Prepared by: New York City Regional Office

Issue Date: Jan 26, 2023

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.



Child Fatality Report

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: 2 month(s)

Jurisdiction: Kings
Gender: Female

Date of Death: 09/02/2022
Initial Date OCFS Notified: 09/02/2022

Presenting Information

The Administration for Children's Services (ACS) received a report from the SCR alleging that on 9/2/22, the 2-month-old female subject child fell asleep, facedown, on the father's chest. After an unknown length of time, the father noticed the child was having difficulty breathing and called 911. The child was transported to the hospital and pronounced dead on arrival at 7:30AM.

Executive Summary

On 9/2/22, ACS received a report regarding the death of the 2-month-old female subject child who died on the same date. At the time of the child's death, she resided at home with her father. The mother resided outside the home and there was an OP barring her from unsupervised contact with the child. There were no siblings or other children in the home. The family was known to ACS as there was an open Preventive Services case at the time of the subject child's death, which had been open since 6/22/22, as well as multiple historical investigations.

The investigation revealed the subject child was fussy and crying at approximately 3:00AM on 9/2/22. The father took the child out of her bassinet and attempted to console her. The father laid down on his bed with the subject child resting on his chest and fell asleep. During the night, the father rolled onto the subject child and found her in the morning unresponsive. The father called 911 at 6:41AM and attempted CPR while awaiting the arrival of first responders. The child was transported to the hospital and arrived in cardiac arrest. Attempts to resuscitate the subject child were unsuccessful and she was pronounced deceased at 7:30AM.

ACS coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final autopsy report was not yet received at the time this report was written. The law enforcement investigation remained open, pending the final report.

ACS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, community-based service providers, and relatives. ACS provided fatality-related services to the family upon receipt of the fatality report.

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? 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?

Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?

Yes

Was there sufficient documentation of supervisory consultation?

Yes, the case record has detail of the consultation.

Explain:

ACS conducted a thorough investigation which met regulatory requirements. Once case objectives were met, ACS determined and closed their investigation and the Preventive Services case that was open at the time of death as the parents had no other children in their care.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities**Incident Information**

Date of Death: 09/02/2022

Time of Death: 07:30 AM

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

Unknown

County where fatality incident occurred:

Kings

Was 911 or local emergency number called?

Yes

Time of Call:

06:41 AM

Did EMS respond to the scene?

Yes

At time of incident leading to death, had child used and/or ingested alcohol or drugs?

N/A

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

NY-22-071

FINAL

Page 4 of 11



Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Other Household 1	Mother	No Role	Female	21 Year(s)

LDSS Response

On 9/2/22, ACS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, ACS initiated their investigation within 24 hours and coordinated efforts with their MDT. ACS reviewed the family's history, which revealed significant CPS involvement, including an open services case unrelated to the fatality.

ACS interviewed the father in the independent living facility where he and the subject child resided. The father reported he last fed the child between 10:00PM and 11:00PM on 9/1/22. He then placed the child to sleep in her bassinet. The father reported he was aware of safe sleep guidance and tried to adhere to recommendations for safe sleep. The child woke and was crying sometime after 2:00AM on 9/2/22. The father picked the child up and began to rock her while he FaceTimed with a friend. The father reported it was not his intention to fall asleep with the child and he planned to place her back to sleep in her bassinet. The father explained that he laid down in his bed and held the child in his right arm, with the child's head resting in the crease of his arm. The father woke around 6:35AM, and realized he was no longer holding the child in his arm. The father found the child facedown on her stomach, blue in color, and not breathing. The father called 911 and attempted CRP at the direction of the 911 operator. The child was transported to the hospital by first responders and pronounced deceased upon her arrival.

ACS interviewed the mother who was not present at the time of the fatal incident. There was an OP against the mother regarding the subject child, and a neglect petition had been filed by ACS. The mother had supervised visitation with the child until her death but was inconsistent with visits. The mother could not provide further information on the death of the subject child. The mother's mental health had been declining rapidly and ACS worked with community-based services to assist in mental health treatment, bereavement counseling, and finding safe and suitable housing for the mother following the death. At the time the investigation was closed, the mother had been admitted inpatient to a mental health facility. Follow-up revealed the mother displayed disorganized behaviors, had not made progress in her treatment, and there was no discharge date.

ACS spoke with the medical examiner who revealed there was no trauma or abuse to the subject child. The medical examiner presumed the death was the result of positional asphyxiation due to the unsafe sleep environment. The medical examiner shared that the father demonstrated a reenactment of falling asleep while holding the subject child and then finding her unresponsive, with her face pressed against his body the following morning.

ACS determined there was evidence to substantiate the allegation of Inadequate Guardianship against the father regarding the subject child. ACS determined that the father failed to provide a minimum standard of care when he failed to adhere to safe sleep practice. Additionally, the medical examiner preliminarily reported the cause of death was expected to be positional asphyxiation due to the unsafe sleep environment. ACS unsubstantiated the allegation of DOA/Fatality against the father, citing that the final autopsy report was not received back yet, thus there was not a fair preponderance of evidence to support the allegation that the father intentionally caused the death of the subject child.

Official Manner and Cause of Death



Child Fatality Report

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**Comments:** ACS adhered to previously approved protocols for joint investigations by coordinating efforts with law enforcement and notifying the DA's office of the death.**Was the fatality referred to an OCFS approved Child Fatality Review Team?** No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062408 - Deceased Child, Female, 2 Mons	062409 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
062408 - Deceased Child, Female, 2 Mons	062409 - Father, Male, 30 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?	☒	☐	☐	☐
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 relevant collateral sources.

Fatality Safety Assessment Activities



Child Fatality Report

	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.

Have any Orders of Protection been issued? No

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:

ACS provided referrals for grief and mental health counseling to the mother and father. ACS provided referrals and assistance to the mother for housing.



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? N/A

Explain:

There were no siblings or other children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

Fatality-related referrals were provided to the family.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	N/A
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 | ☐ Used illicit drugs |
| ☐ Had a positive toxicology at the time of delivery | ☐ Used prescription drugs |
| ☐ Used marijuana | ☐ Was not noted in the case record to have any of the issues listed |

Infant was born:

- | | |
|---|---|
| ☐ With a positive toxicology | ☐ With fetal alcohol effects or syndrome |
| ☐ Exhibiting withdrawal symptoms | ☒ 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)
06/22/2022	Deceased Child, Female, 1 Days	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 1 Days	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Days	Mother, Female, 21 Years	Inadequate Guardianship	Substantiated	



Child Fatality Report

Report Summary:

ACS received a report from the SCR alleging that on 6/21/22, the mother gave birth to the subject child. The mother had an extensive psychiatric history, was diagnosed with bipolar disorder and schizophrenia and was not receiving treatment for the conditions. The mother was talking to herself in multiple languages, was not forthcoming with information for medical staff, and had no provisions for the subject child. A subsequent report was received and alleged the father used illicit substances while caring for the child.

Report Determination: Indicated**Date of Determination:** 08/06/2022**Basis for Determination:**

ACS determined there was credible evidence to support the allegation of IG against the mother. The mother had no provisions for the child and was admitted inpatient to a psychiatric hospital following the birth of the subject child without making a plan for her care. The mother was not engaged in treatment prior to the birth and was not a discharge resource for the subject child. There was no evidence that the father was an inappropriate caregiver for the child and no evidence he was using illicit substances. ACS opened preventive services for ongoing support for the father and subject child.

OCFS Review Results:

ACS consulted with their legal department and filed an Article 10 Neglect Petition. ACS spoke with all relevant collateral sources and provided court ordered supervision to the parents. ACS appropriately determined the investigation once case objectives were met.

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 history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes

Date the preventive services case was opened: 06/22/2022

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts



Child Fatality Report

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The initial FASP was completed 7 days after the due date.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: A community-based contract agency provided support and preventive services to the family.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was completed 7 days after the due date.
Legal Reference:	18 NYCRR428.3(f)
Action:	ACS will complete timely and accurate FASPs.



Preventive Services History

At the time of the child's death, a Family Services Stage (FSS) was open to provide support and assistance to the father. The FSS was opened on 6/22/22, following the child's birth. An article 10 Neglect Petition had been filed against the mother and court ordered services were being provided to the father. The mother was not a viable resource for the child due to her ongoing mental health concerns and failure to adhere to treatment recommendations. The father was engaged in services related to parenting skills and was compliant with ACS and community-based providers. The FSS was closed on 9/30/22, as there were no other children in either parents' care.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to 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:
06/24/2022	There was not a fact finding	Order of Supervision
Respondent:	062410 Mother Female 21 Year(s)	
Comments:	On 6/24/22, an Article 10 Neglect Petition was filed against the mother regarding the subject child. ACS sought a remand to foster care due to concerns for the mother's mental health. The child was released to the father's care with ACS oversight. On 8/18/22, a hearing on the neglect was held and preventive services were court ordered.	

Have any Orders of Protection been issued? Yes

From: 06/24/2022

To: Unknown

Explain:

The mother was ordered to stay away from the subject child and father.

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