Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-077

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

Issue Date: Jan 07, 2025

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: Bronx
Gender: Male
Date of Death: 08/09/2024
Initial Date OCFS Notified: 08/12/2024

Presenting Information

An SCR report was received on 8/12/24, which alleged that on 8/9/24, the mother breastfed the 4-month-old subject child and placed him in his Pack 'N Play, on his back, with a blanket over his chest. The mother checked on the child 2 hours later, at 9:00PM, and found the child face down with his head to the side, unresponsive. As the mother attempted to wake the child, the father called 911. The child was taken to the hospital where he was pronounced deceased in the emergency department at 10:07PM. The child was an otherwise healthy child. A subsequent report was received on 10/22/24, which alleged the child tested positive for cocaine and the parents had no explanation for the child's positive toxicology results.

Executive Summary

This report concerns the death of the 4-month-old subject child. The New York City Administration for Children's Services (ACS) received an initial SCR report regarding the child's death on 8/12/24. The child's death occurred on 8/9/24. At the time of the child's death, he resided with his mother, father, and three siblings: ages 9, 3, and 1. An additional SCR report was received on 10/22/24, after the investigation into the initial report had been determined and closed.

On the evening of 8/9/24, the mother breastfed the child around 6:00PM, then fell asleep in bed with the child. The mother woke up around 6:45PM, at which point she laid the child down in his crib, on his back. The mother placed a blanket on the child, which came up to his chest. When the mother checked on the child about 2 hours later, the child was limp. The mother brought the child into the living room and saw the child's lips were blue. The mother yelled to the father for help, and the father called 911. While the father was on the phone with dispatch, the mother tried to rouse the child by throwing water on his face. The family was directed by 911 dispatch to perform cardiopulmonary resuscitation (CPR), which the mother did until emergency medical services (EMS) arrived and took over. EMS transported the mother and child to the hospital, where the child was later pronounced deceased at 10:07PM.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the initial CPS investigation closed as there were still outstanding test results. Upon completion of the remaining tests, it was learned the child's toxicology was positive for cocaine at the time of death. That new information generated a subsequent SCR report to be made. The autopsy report was updated, and the cause of death was "acute cocaine intoxication," and the manner of death was homicide. Law enforcement's investigation remained ongoing, and no arrests had been made at the time of writing.

ACS completed home visits and interviewed the parents. Following receipt of the child's finalized toxicology report, ACS accessed family court, and the siblings were removed from the parents' care. Both parents were interviewed following the subsequent SCR report and denied the use of cocaine or knowing how the child encountered the substance.

The initial SCR report made on 8/12/24 contained allegations of Inadequate Guardianship and DOA/Fatality. ACS substantiated the allegation of Inadequate Guardianship against the mother and father due to their admittance of bedsharing with the subject child on occasion. The child did have access to safe sleep provisions. The allegation of DOA/Fatality was unsubstantiated. At that time, the medical examiner reported no evidence of foul play, and the autopsy

report was pending. The medical examiner explained the child was able to turn to his side on his own and that there was no evidence the blanket the mother placed on the child moved over his face. ACS made a determination consistent with the facts available to them at the time. The subsequent SCR report contained the additional allegation of Poisoning/Noxious Substance against both parents. That investigation remained ongoing.

Initially, the family accepted a multitude of services and referrals offered by ACS and a corresponding services case (FSS) was opened. The FSS remained open as the siblings were now in direct placement.

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:

The citations in this report are related to the initial 8/12/24 investigation. Regarding that investigation, a determination of allegations was made in congruence with available information at the time the determination was due. The subsequent 10/22/24 investigation remained pending.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	There was no 7-Day Safety Assessment completed in CONNECTIONS for this investigation.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-Day Safety Assessment in CONNECTIONS.

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	Elevated risk elements were scored incorrectly. Parental surrenders are not a legal indication of a family court finding of permanent neglect and therefore do not apply to the risk element regarding prior TPRs.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/09/2024 **Time of Death:** 10:07 PM

Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Yes
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	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

On 8/12/24, ACS received a report regarding the death of the subject child, which occurred three days prior. ACS initiated their investigation immediately and coordinated with law enforcement. ACS contacted the source of the report, completed a CPS history check regarding the family which revealed prior child welfare involvement, and informed the DA of the fatality. ACS assessed the safety of the siblings and conducted an initial home visit the same day. Upon receipt of the subsequent report, the DA was updated, and the safety of the siblings was re-assessed based on the new information available.

ACS interviewed the parents regarding the events leading up to the child's death. Both parents offered similar accounts. The mother described their routine of the parents waking at 6:00AM with the subject child. Typically, the father then got ready for work while the mother would feed the child; however, that day the father did not go to work. When the siblings woke up, the parents changed diapers, the siblings took showers, and then had breakfast. Around 11:00AM, the children had lunch and took naps. The 1 and 3yo siblings napped in the parents' bedroom, while the 9yo sibling played video games in his room. At 6:02PM, the mother breastfed the child, then the mother and father fell asleep in the bed. The mother reported the child had been warm and sneezing that day and had not had much milk before the mother laid down with him. The mother woke at 6:45PM and moved the child to his crib, placing him on his back with a blanket. When the mother checked on the child 2 hours later, the child was on his stomach, with his face turned to the right. The mother stated there was nothing blocking the child's nose, there was no vomit on the child's face or in the crib, and nothing was in the crib except the blanket. The mother grabbed the child, and he was limp. She put on her glasses and went into the living room for better light and noticed the child's lips were blue and his feet were cold. The mother yelled out for help to the father, and the father reported he awoke to her yelling at about 9:00PM. The father called 911 and remained in the home while EMS transported the mother and child to the hospital. The mother and child arrived at the hospital at 9:35PM. According to hospital staff, the child's appearance showed no trauma. His lips were blue, his skin was cold to the touch, and he was unresponsive. The child was pronounced deceased at 10:07PM.

The siblings were assessed and the 9yo sibling was interviewed, and offered no additional information related to the fatality. During the investigation, concerns regarding the physical living conditions were noted and ACS helped the family with addressing mold and pest infestations. Additionally, ACS offered homemaking services to the mother, which she accepted, though the service was discontinued when it was no longer needed. ACS provided daycare assistance, completed an Early Intervention referral on behalf of the 1yo sibling, provided furniture referrals, Health Home referrals, and offered preventive services to the family, which they accepted.

ACS communicated with the ME and law enforcement throughout the investigation and again upon receipt of the subsequent report. The ME stated the child could have ingested cocaine several ways, such as through breast milk, the child touching a surface with cocaine on it, or someone giving it directly to the child. The parents were interviewed again following the updated toxicology report. Both denied the use of cocaine; however, they were both positive for cocaine when tested.

ACS filed an Article 10 petition in family court on 10/24/24, requesting the removal of the siblings. The removal was granted, and the siblings were directly placed with the maternal grandmother.

The family remained under court-ordered services at the time this report was written.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external 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 Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
068929 - Deceased Child, Male, 4 Month(s)	068934 - Father, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
068929 - Deceased Child, Male, 4 Month(s)	068934 - Father, Male, 36 Year(s)	Inadequate Guardianship	Substantiated
068929 - Deceased Child, Male, 4 Month(s)	068933 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
068929 - Deceased Child, Male, 4 Month(s)	068933 - Mother, Female, 34 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	☐	☒	☐	☐
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:
ACS filed a petition in family court upon receipt of new information regarding the child's cause of death.

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:
10/24/2024	There was not a fact finding	Custody Transferred to Relative or Non-Relative Foster Care

Respondent:	068933 Mother Female 34 Year(s)
Comments:	ACS filed a petition in family court on 10/24/24 and requested the removal of the siblings. The siblings were placed via FCA 1017 with the maternal grandmother. The parents were required to submit to substance use testing. Court proceedings remained ongoing.

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A

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	☒	☐	☐	☐	☐	☐
Preventive Services	☒	☐	☐	☐	☐	☐
Other	☒	☐	☐	☐	☐	☐

Other, specify: community-based services

Additional information, if necessary:
In addition to fatality-related services, ACS completed community-based referrals for the family including Early Intervention, 311, pest control, provided daycare assistance and furniture assistance. The grandmother was used as a placement resource once family court proceedings were initiated. Substance use treatment was initiated for the mother, the father's status was unknown.

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The eldest sibling received counseling services through his school.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The mother reported being engaged in bereavement counseling. The father's engagement was unknown.

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

The mother had additional history with ACS dating back to 2010. Regarding a child subsequently adopted, the mother was substantiated for Parent's Drug/Alcohol Misuse and Inadequate Guardianship in 2010 and 2011. The corresponding services case regarding that child is not reflected in this report.

Regarding the children subject to this report, the father was substantiated for Inadequate Guardianship in 2017 regarding the now 9yo sibling. The father physically assaulted the mother in the presence of the sibling, who was 2 years old at the time, and was arrested as a result. A separate incident occurred in which the mother "attacked" the father in the presence of the sibling. The resulting fight turned physical and had to be broken up by a third party. While the Investigation Conclusion Narrative indicated the mother would also be substantiated for Inadequate Guardianship, the record did not reflect she was. The mother accepted a preventive services case, which opened on 11/14/17. The father was again substantiated for Inadequate Guardianship of that same sibling in 2018. The Investigation Conclusion Narrative offered no explanation regarding that finding.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A services case was open from 11/14/17 to 1/23/19 with the mother, father, and now 9yo sibling. The case opened following an indicated CPS investigation regarding domestic violence. The mother accepted services for herself and the sibling. Initial goals were for the mother and sibling to receive counseling services. Services were provided by a contract agency. The mother was engaged in services during the open case. At the time of case closing, there were no identified safety factors and risk elements were low. The mother demonstrated the ability to meet the sibling's needs and had relocated to a domestic violence shelter where she was able to receive additional supports. At closing, the mother had stable housing, the sibling was enrolled in educational programming and mental health services, and the relationship between the mother and the father had reportedly ended.

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