Child Fatality Report

Report Identification Number: NY-24-073

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

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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: Bronx
Gender: Male
Date of Death: 07/23/2024
Initial Date OCFS Notified: 07/23/2024

Presenting Information

An SCR report was received that alleged on 7/23/24, at 6:00AM, the father fell asleep with the 1-month-old subject child on the bed. At 8:54AM, the father woke and found the subject child partially underneath his side and unresponsive. The father immediately called 911 and was instructed how to perform cardiopulmonary resuscitation (CPR). Emergency medical services arrived at the home at 9:00AM and they attempted cardiopulmonary resuscitation. The subject child was transported to the hospital by ambulance. Despite further attempted life-saving measures, the subject child was pronounced deceased at 9:51AM. The unsafe sleeping conditions were suspected to have contributed to the child's death.

Executive Summary

This report concerns the death of a 1-month-old male child that occurred on 7/23/24. The New York City Administration for Children's Services (ACS) received an SCR report on that same date, regarding the fatality. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the father. At the time of his death, the subject child resided with his mother, father, and surviving siblings ages 4 and 2 years old. In addition, there were 3 half-siblings who resided with their mothers. The whereabouts of the 4-year-old sibling's biological father remained unknown. ACS immediately initiated their investigation and assessed the surviving siblings to be safe in the care of their parents. ACS assessed the 15- and 5-year-old half-siblings to be safe and made multiple attempts to obtain locating information for the other 15-year-old half-sibling; however, were unsuccessful.

Through a joint investigation with law enforcement, it was learned in the early morning on 7/23/24, the father returned home from work around 4:30AM. The father changed and fed the subject child and told the mother to go to sleep. The father woke around 8:50AM and found the subject child unresponsive. The mother contacted 911 while the father attempted CPR. Emergency medical services arrived and took over life-saving efforts. The subject child was transported to the hospital and pronounced deceased at 9:51AM.

ACS communicated with the medical examiner's office and learned an autopsy was performed on 7/24/24, and there were no external signs of injuries or trauma. It was noted that the subject child had rib fractures, which were believed to be from resuscitative efforts. The Office of Children and Family Services (OCFS) received the subject child's autopsy report. The cause of death was listed as sudden unexplained death (with intrinsic and extrinsic factors), and the manner of death was listed as undetermined.

ACS communicated with law enforcement and learned there were no concerns for injuries or trauma to the subject child or suspicion of foul play. Law enforcement explained the death appeared to be a result of an accidental rollover. In addition, there were no criminal charges filed against the father.

ACS substantiated the above referenced allegations based on information that was obtained. ACS determined that the actions or inactions of the father contributed to the subject child's death. The father fell asleep on a couch while holding the subject child and did not utilize a safe sleeping environment. The 24 and 30-day fatality reports were completed timely and accurately. The Risk Assessment Profile was consistent with case circumstances and required notifications were provided to the parents. ACS gathered information from collateral contacts such as law enforcement, family

members, neighbors, and the medical examiner's office. ACS utilized interpreter services for the family to assist with any language barriers. The family was offered bereavement services which they accepted. In addition, burial assistance was discussed with the family and preventive services were offered and accepted by the parents.

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:
ACS made an appropriate decision to substantiate the allegations of Inadequate Guardianship and DOA/Fatality based on evidence obtained throughout their investigation.

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

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:
Casework activity was commensurate with case circumstances.

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: 07/23/2024 **Time of Death:** 09:51 AM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 08:50 AM
Did EMS respond to the scene? Yes
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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 7/23/24, ACS received a report regarding the death of the subject child which occurred on that same date. ACS initiated their investigation within 24 hours, notified the district attorney and communicated with the medical examiner, and coordinated their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history check, and immediately assessed the surviving siblings to be safe.

ACS completed an interview with the mother at the home. During her interview, the mother reported the father returned home from work around 4:30AM. The father proceeded to enter the bedroom where the mother and subject child were located and woke the subject child. The mother told the father to eat something which he said he would after he helped with the subject child. The mother reported the father then took the subject child and changed his diaper on the parents'

bed. The mother explained she told the father she would tend to the subject child so he could eat and relax, but he insisted on caring for the child and told the mother to get some sleep. The father took the subject child into the living room where the mother believed he was being fed. The mother fell asleep and woke to the father yelling that the subject child was not breathing. The mother contacted 911 at 8:50AM, while the father attempted CPR. The mother denied concerns for the father's ability to care for the children.

ACS completed an interview with the father at the home. During his interview, he explained he returned home from work around 4:30AM after working a double shift. The father brought his tools into the bedroom and the noise woke up the subject child. The father went over to the subject child picked him up and noticed he needed a diaper change, so he placed him on the bed and proceeded to change the subject child. The father then told the mother he would take the subject child into the living room so the mother could get some rest. The father heated up some food and proceeded to eat on the couch where he placed the subject child. The father reported he then fed the subject child and burped him while holding him on his chest. The father became emotional during the interview and explained he did not remember falling asleep but noted when he woke, he was lying on his back on the sofa and he did not see the subject child. Initially, the father thought that the mother took the child as it was around the time that the family wakes up. The father then explained he saw the subject child lying face down in between him and the sofa cushions. The father observed that the subject child was unresponsive as he was not moving or breathing. He then took the subject child to the mother who contacted 911 while the father attempted CPR until first responders arrived.

Interviews were completed with the surviving sibling, there was no additional information provided regarding the fatal incident or concerns regarding the parents. In addition, ACS communicated with numerous family members who denied having concerns for the children or the mother and father's parenting abilities.

ACS completed an Initial Child Safety Conference (ICSC) with the parents. The parents were offered preventive services which the family accepted. A Family Services Stage (FSS) was opened on 7/25/24, and the CPS investigation was closed on 9/26/24. At the time of case closure, the FSS remained open with the family receiving supportive services.

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: 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
069448 - Deceased Child, Male, 1 Month(s)	069449 - Father, Male, 36 Year(s)	DOA / Fatality	Substantiated

069448 - Deceased Child, Male, 1 Month(s)	069449 - Father, Male, 36 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?	☒	☐	☐	☐

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	☒	☐	☐	☐

Explain:
ACS offered the family preventive services which they accepted and were actively participating in at the time this report was written.

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 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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
ACS referred the father for a CASAC assessment due to his marijuana use. The mother and father were referred for domestic violence services as there were a couple instances of law enforcement involvement.

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 family was offered bereavement services which the family accepted. In addition, ACS completed referrals for the surviving siblings to engage in play therapy and early intervention. ACS offered the family preventive services which the family accepted and were actively participating in at the time this report was written.

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 parents were provided with information for bereavement services which they accepted. Burial assistance was discussed, and preventive services were offered which the parents accepted and were actively participating in at the time this report as written.

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 knowns 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