Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-094

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

Issue Date: Feb 20, 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: 1 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 10/01/2024
Initial Date OCFS Notified: 10/01/2024

Presenting Information

An SCR report received on 10/01/24 alleged that on that date, in the morning, the mother rolled over on top of the 1-month-old subject child, causing the child to suffocate. Around 1:00PM, the mother woke up to find the child unresponsive, bleeding from his left nostril, and his left arm was purplish in color. At 1:14PM, the mother called 911 and emergency medical services (EMS) was dispatched to the home. The mother attempted cardiopulmonary resuscitation (CPR) at the direction of EMS while EMS was en route to the home. The child was transported to the hospital for emergency medical treatment. Despite life-saving efforts, the child was pronounced deceased at 1:59PM.

Executive Summary

This report concerns the death of the 1-month-old subject child. The Administration for Children's Services (ACS) received an SCR report regarding the child's death on 10/01/24. At the time of the child's death, he resided with his mother, father, and three siblings (ages 4, 12, and 14).

The night prior to the fatal incident, the mother did not sleep well. The 4-year-old sibling did not sleep through the night, and the subject child had colic and congestion, only sleeping every 2 hours. The morning of 10/01/24, the father woke at 5:00AM to get ready for work. The mother got the three siblings off to school and returned to the home with the child. The mother fed the child formula and Gripe water and anticipated taking the child to the pediatrician later that day for scheduled immunizations and to address his congestion. The mother cleaned the home, and spoke on the phone with the father, who was at work. The mother asked the father to call and wake her at 11:00AM to move the car for street cleaning, and the mother set an alarm for 10:40AM as well. The mother placed the child in his crib, next to her bed, but the child cried. The mother picked the child up and placed him on the far-right side of the bed, and she laid down on the far-left side of the bed. The mother fell asleep and slept through the father's calls and the alarm, not waking until about 1:00PM, at which point the child's head was under the mother's stomach. When she turned the child over, the mother observed blood from his nose, and he was not breathing. The mother called 911 and the operator instructed her to perform CPR until the ambulance arrived. The child was taken to the hospital via ambulance. After multiple rounds of CPR and life-saving medication, without a return of spontaneous circulation and no cardiac activity seen, the child was pronounced deceased at 1:59PM.

The medical examiner was notified and performed an autopsy. The final autopsy report remained pending at the time the CPS investigation was closed; however, the medical examiner reported the manner of death was likely "undetermined." The cause of death was anticipated to be attributed to sudden infant death syndrome (SIDS). The medical examiner further explained SIDS was a broad diagnosis with different categories. In relation to this death, there was an external factor of co-sleeping, and an internal factor of the child testing positive for COVID-19. When asked if co-sleeping could have caused the child's death, the medical examiner stated, "definitely." Law enforcement had not made any arrests in relation to the death.

The family relocated from their home immediately following the fatality. ACS completed home visits where the family was temporarily residing. The mother, father, and multiple relatives close to the family were interviewed. All siblings were assessed to be safe in the parents' care.

ACS determined the mother demonstrated poor judgment in placing the child in an unsafe sleep environment while being admittedly sleep-deprived and a "heavy sleeper." The mother slept through two phone calls and an alarm. Although a crib was available to the child, and safe sleeping recommendations were known, the mother admitted to co-sleeping with the child, finding the child underneath her upon waking. ACS substantiated the allegations related to the fatality and offered the family preventive services, which they accepted.

The mother was engaged in bereavement counseling at case closing, and the family had begun engaging in Functional Family Therapy (FFT) through a preventive contract agency, as offered by ACS. Due to the family receiving contracted services, a family services stage (FSS) was opened, and casework activity continued within the FSS.

PIP Requirement

For citations identified in historical cases, 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:

The determination to indicate was made in congruence with evidence gathered and collateral reports of the circumstances surrounding the child's death.

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:
The family accepted a services referral for FFT, thus an FSS was opened and the family was engaged in services at the time the CPS investigation was determined.

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: 10/01/2024 **Time of Death:** 01:59 PM

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

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 01:14 PM
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	No Role	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

Other Household 1	Other Adult - Father to 12 and 14yo siblings	No Role	Male	35 Year(s)

LDSS Response

On 10/01/24, ACS received a report regarding the death of the 1-month-old subject child. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history check regarding the family, which revealed prior history with ACS, and informed the DA of the fatality. ACS assessed the safety of the siblings and conducted multiple home visits throughout the investigation to where the family and siblings were temporarily residing.

ACS completed an array of interviews with the parents, relatives, and pertinent collaterals. All those interviewed presented a timeline and description of events that did not differ from the mother's account of the incident. The night before, the mother had not slept well. The 4yo sibling did not sleep through the night and kept running around, taking dirt out of the flowerpot and throwing it everywhere. Additionally, the subject child had colic and was congested. As such, he only slept every 2 hours. When the father woke at 5:00AM for work, the 4yo sibling woke again as well and was running around the home. The eldest siblings woke later and readied themselves for school while the mother got the 4yo sibling ready. The eldest siblings went to school on their own and the mother walked the 4yo sibling with the subject child in a babywearing carrier to the school bus stop. After the sibling got on the bus, the mother went to the store and then returned home with the child. She fed the child formula and Gripe water, for his colic. The mother had spoken to the father over the phone and had asked him to call at 11:00AM to wake her, and she had also set an alarm for 10:40AM. After the child finished his formula, the mother burped him, and he fell asleep. The mother placed him in his crib, but the child cried. The mother placed the child on the opposite side of the queen-sized bed and fell asleep in bed with the child. The mother reported she was a deep sleeper and was very tired. When she woke up around 1:00PM, the child's head was under her stomach, there was blood coming out of his nose, and his arm was blue or purplish in color. The mother called 911 and started CPR as instructed. EMS arrived at the home, as did law enforcement, and the child was transported to the hospital.

ACS spoke to the medical examiner, who stated co-sleeping created an impact on the death. Toxicology results yielded nothing concerning. ACS learned from hospital staff that a skull assessment showed no signs of fracture, and a body check revealed no bruising to the child's torso, back, or extremities. The child had been born full term with no concerns and had been a well child.

ACS contacted numerous collateral sources, including family, schools, medical staff, law enforcement, the pediatrician, and the medical examiner. Although ACS did not document contacting first responding EMS, given the corroboration of all interviewed parties, there was likely no additional information needed to make an informed determination of the allegations. ACS offered the family information on bereavement services and opened a preventive services case. The family had begun engaging in in-home therapy services at the time the CPS investigation was closed.

Official Manner and Cause of Death

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

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
069895 - Deceased Child, Male, 1 Month(s)	069896 - Mother, Female, 31 Year(s)	DOA / Fatality	Substantiated
069895 - Deceased Child, Male, 1 Month(s)	069896 - Mother, Female, 31 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?	☐	☒	☐	☐

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:
The family accepted preventive services and engaged in family therapy. The mother had begun engaging in grief counseling; however, the father had not. Based on the father's history, a substance use referral was made, though there were no current reports of substance use concerns. The family was engaged in services at the time the CPS investigation closed.

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:
In response to the fatality, the mother accepted a services referral on behalf of the family, and the siblings were receiving in-home family therapy. Additionally, the eldest siblings' school provided access to counseling support for the siblings. The 4yo sibling had services in place through his school prior to the fatality.

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:
Funeral expenses were paid for by the hospital, and the mother engaged in grief counseling. ACS provided the family with bereavement service information, and the family accepted a preventive services referral for FFT.

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? Yes

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/06/2023	Sibling, Female, 13 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Open	Yes
	Sibling, Female, 13 Years	Mother, Female, 30 Years	Lack of Medical Care	Far-Open	

Report Summary:
An SCR report received on 10/06/23 alleged that the now 14yo sibling (then 13) was diagnosed with a mental health disorder and had suicidal ideation and engaged in self-harming behaviors. On 10/06/23, the sibling experienced such ideation and intervention was required. The mother failed to provide the sibling with proper mental health or medical care. As a result, the sibling continued to experience such behaviors, placing her at risk of harm.

OCFS Review Results:
The reported concerns were addressed with the mother, and the mother was provided the option to participate in Family

Assessment Response (FAR) rather than a traditional CPS investigation. The mother participated in the FAR case, and the family was linked to services. An FSS was opened to provide FFT in a home-based setting through a contract agency. Services had begun prior to the FAR case closing. Both the eldest siblings were referred to school-based counseling. School attendance for all three siblings was consistent. Neither of the father's were listed, notified, or engaged in the FAR case, despite their reported involvement with their children.

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

Issue:

FAR-Failure to Provide Notice of Report

Summary:

Neither of the siblings' fathers were sent the required notification of the report regarding their respective children, despite being reportedly actively involved with their children.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:

No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:

Adequacy of Progress Notes

Summary:

There was one instance of a progress note being entered seemingly regarding another family, and one instance of an incomplete progress note containing no information or addendum explaining its purpose.

Legal Reference:

18 NYCRR 428.5

Action:

ACS will accurately document all casework activity into progress notes.

[redacted]

CPS - Investigative History More Than Three Years Prior to the Fatality

2/25/21 – 4/26/21 The allegation of Educational Neglect was unsubstantiated against the mother regarding the now 14 and 12yo siblings (then 10 and 8). The siblings had poor school attendance; however, it improved during the investigation and the school reported daily engagement in virtual learning and the school provided Individualized Education Program (IEP) services. The mother accepted a preventive services case for additional support.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

4/19/21 – 1/9/23 The mother and siblings were listed on an FSS. The case was opened following an unfounded SCR report regarding the then 10 and 8yo siblings' school attendance. The mother voiced difficulty managing the 8yo sibling's behaviors as well and wanted to learn new skills on how to effectively communicate with the 10 and 8yo siblings. A

contract agency provided services. The record reflected the mother was actively involved in pursuing case plan objectives. Housing stability was addressed, the siblings' school attendance improved and they attended consistently, and at case closing, the medical needs of all the siblings were up to date. There were no child welfare concerns identified at the time the preventive services case closed.

11/8/23 – 2/22/24 The mother and siblings were listed on an Advocates Preventive-Only (ADVPO) case. Per previously established documentation requirements, ADVPO records are maintained partly outside the CONNECTIONS system. These preventive-only cases do not require completion of contacts and progress notes or Family Assessment and Service Plans (FASPs) to be completed within CONNECTIONS; therefore, those documents were not available for this review.

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