Child Fatality Report

Report Identification Number: NY-24-105

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

Issue Date: Apr 18, 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: 2 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 11/21/2024
Initial Date OCFS Notified: 11/21/2024

Presenting Information

On 11/21/2024, ACS received an add information to their open foster care case regarding the death of a child in ACS care. On 11/21/2024, an outside provider notified the regional office of the child's death via a 7065-agency reporting form. The information that was provided in the additional information report and via the 7065-form reported that on 11/20/2024, the 2-month-old was running a fever, the degree in which was unknown. The foster mother took the child to the ER, who recommended her to follow up with the primary care physician. On the morning of 11/21/2024, the foster mother took the child to the primary care doctor, who advised that the foster mother take the child to the ER, as her condition had deteriorated rapidly. The child was transported to the ER via ambulance. Several hours later, while awaiting diagnostic testing results the child coded and died.

Executive Summary

This fatality report concerns the death of a 2-month-old female child. The New York City Administration for Children's Services (ACS) had an open foster care case at the time of the child's death. The death was reported to the regional office on 11/21/2024. The foster care case was opened regarding concerns that the mother had 7 previous children removed from her care due to the siblings being born with positive toxicology screens. The mother had a long history of drug use and had admitted to using cocaine and heroin on the day that she delivered the subject child. The subject child was born with positive toxicology screens and was experiencing withdrawals. The mother presented a maternal cousin as a resource for the subject child. The child was placed in ACS custody on 09/18/2024; however, remained in a long-term care children's hospital until discharge from the hospital to the maternal cousin via kinship care. On 11/07/2024, the maternal cousin became the foster mother, and the subject child resided with her at the time of her death. The surviving siblings were freed for adoption prior to the subject child's death. There were no other children residing in the foster mother's home.

On 11/21/2024, the foster mother contacted the agency asking to take the subject child to the medical clinic. On 11/20/2024, the subject child developed a fever, and the foster mother was able to treat it with a fever reducer. On 11/21/2024 the foster mother reported that the subject child's fever had reduced; however, the subject child was listless and not herself. The agency agreed to meet with the foster mother at the medical clinic; however, upon arrival to the clinic the subject child's temperature was taken and was said to be 105 degrees. The physician advised that the child be transported via ambulance to the emergency room at 4:18pm. Upon arrival at the emergency room the subject child had coded for around 10 minutes. Medical staff were able to revive the subject child. Once the subject child was stabilized, diagnostic testing began in an effort to diagnose and treat her symptoms. While waiting for results, the subject child's condition worsened. At 7:18pm, the subject child coded again, and for 40 minutes medical staff worked diligently administering life saving techniques to no avail. The subject child was pronounced deceased at 7:59PM.

ACS had communication with LE regarding the death; however, they declined to investigate, citing the child passed away due to medical issues. Law enforcement advised that if ACS obtained new information that suggested suspicious activities led to the subject child's death, then law enforcement should be alerted immediately. At the time this report was written, there was no reason to suspect a crime had been committed.

ACS spoke with the medical examiner's office on 11/25/2024 regarding the autopsy. The medical examiner reported that

the autopsy was completed on 11/22/2024, however, the autopsy results were pending and would not be available for 4-5 months. There were no preliminary signs of abuse or neglect.

ACS discussed service needs with the family and offered the family burial and bereavement services. The mother discontinued working with an outside provider after the subject child's death and she was unable to be located.

The foster care case was closed on 01/09/2025, noting the child's death. The initial and comprehensive assessments were completed on time and assessments were completed regularly throughout the duration of the case. ACS made regular required visits with the mother, foster mother and the subject child throughout the case.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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:
The SC had surviving siblings at the time of death; however, the SSs were placed freed for adoption prior to the fatality.

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: 11/21/2024 **Time of Death:** 08:01 PM

Time of fatal incident, if different than time of death: 07:59 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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	No Role	Female	2 Month(s)
Deceased Child's Household	Foster Parent	No Role	Female	22 Year(s)
Other Household 1	Mother	No Role	Female	33 Year(s)

LDSS Response

On 11/21/2024, ACS received an additional information report on their open foster care case regarding the death of the SC. ACS initiated their investigation within 24 hours and attempted to coordinate their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality.

ACS spoke with the FM who reported that the SC had a fever the day before the SC's death. The FM reported that the fever was 100.3-100.4. The FM was instructed to give the child a fever reducer and continue to check the temperature every two hours. The FM logged these checks every two hours, and the fever had gone down. The last check on 11/21/2024 did not show a fever however the FM reported the child being listless and not herself and requested that she be allowed to bring the SC to a clinic nearby the foster home. Upon arrival at the clinic the SC's temperature had risen to 105 and the decision was made that the SC would be transported to the ER via ambulance. The FM reported since getting custody of the SC on 11/07/2024, the child had multiple doctor's appointments and check in home visits with the medical case manager (CM). The FM reported the child was last seen at the doctor's office on 11/19/24 and other than a heat rash, the child was doing well.

ACS spoke with the CM assigned to the case. The CM verified contact from the FM the day before the death reporting a fever. CM advised that the SC be given a fever reducer and do temperature checks to make sure the fever had gone down. The CM reported that on the morning of the fatal incident the CM spoke with the FM who reported the fever had remained

at bay; however, the SC was listless and not herself so they decided a clinic visit would be needed.

ACS spoke with the ER resident physician after the death was pronounced. The physician reported that they believed the subject child's death to be acute respiratory failure with hypoxia and hypercapnia. The physician explained that the child did not have enough air going to her brain, and brain functioning was minimal when she arrived at the hospital. The physician provided ACS with documentation of the ER admission and treatment. The physician reported 4 days after death that only the ME can determine the cause of death; however, the subject child had septic shock and a bacterial infection on the date of her death. The physician could not comment if the child had been seen sooner that the outcome would have been different.

ACS spoke to numerous medical collaterals who reported that the FM followed the appropriate steps in caring for the SC. The child preliminarily died due to medical causes, and the FM did what was appropriate in the circumstances given. The SC was seen by medical professionals three times in the two weeks preceding her death, including 2 days before she passed.

ACS closed their services case after offering the family assistance with the funeral and bereavement counseling. After the death, the BM could not be located. Her location was unknown at the time this report was written. The FM had no other children in her care and the foster care case was closed on 01/09/2025.

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 referred to an OCFS approved Child Fatality Review Team? No

Comments: The New York City Region does not have an OCFS approved CFRT.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

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)	Allegation Outcome	Compliance Issue(s)
09/16/2024	Deceased Child, Female, 1 Days	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 1 Days	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
On 9/15/2024, the subject mother gave birth to the subject child. The SM tested positive for cocaine and opioids at the time of delivery. As a result, from exposure in utero, the infant experienced withdrawals from the cocaine and heroin including constant crying, constant fussing, and sweating.

Report Determination: Indicated | **Date of Determination:** 10/24/2024

Basis for Determination:
The SM had seven other children who were removed from her care due to IG and PD/AM. The SM gave birth to the SC who tested positive for Heroin and Cocaine. The SM admitted using Heroin one hour before giving birth to the SC. As a result, from exposure in utero, the SM experienced withdrawals from the cocaine and heroin including constant crying, constant fussing, and sweating. An Article 10 neglect petition was filed and granted, placing the SC under ACS care. The

maternal cousin was identified as a resource, and a kinship foster placement was completed on 11/07/2024, once the SC was released from the hospital.

OCFS Review Results:
The investigation was completed timely, the SM had an open services case at the time the investigation closed. Collaterals and source contacts were made. The allegations of IG and PD/AM were appropriately determined to be substantiated. ACS did not write an investigation conclusion. ACS did not contact the biological father or show diligent efforts in locating the biological father.

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

Issue:

Case record contains information that is relevant, useful, factual and objective

Summary:

ACS's investigation determined that the allegations of IG and PD/AM were substantiated; however, ACS did not document an investigation conclusion narrative to support their findings.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

PIP Requirement:

For citations identified in historical cases, ACS will submit a PIP to the New York City Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

Supervisory reviews documented instructions to identify the biological father; however, there is no documentation that information was asked or given to identify the biological father or contact him.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ACS will make efforts to make face-to-face contact with a child and/or a child’s parents or guardians and document efforts that were unsuccessful.

PIP Requirement:

For citations identified in historical cases, ACS will submit a PIP to the New York City Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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

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

The biological mother had multiple CPS reports resulting in the termination of parental rights as well as volunteer placements with 7 previous children; however, these surviving siblings were all freed for adoption or adopted at the time of the fatality. The kinship foster mother had no history in NYS prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes
Date deceased child(ren) was placed in care: 09/18/2024
Date of placement with most recent caregiver? 11/07/2024
How did the child(ren) enter placement? Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☒	☐	☐	☐
Did the placement comply with the appropriateness of placement standards?	☒	☐	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐
Did the agency comply with sibling placement standards?	☒	☐	☐	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☒	☐	☐	☐

Was visitation facilitated in accordance with the regulations?	☒	☐	☐	☐
Was there supervision of visits as required?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☒	☐	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's placement location?	☒	☐	☐	☐

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	☒	☐	☐	☐
Did the provider comply with discipline standards?	☐	☐	☒	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☐	☐	☐	☒
If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☐	☐	☐	☒
Was the certification/approval for the placement current?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** Unknown	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:**	☐	☐	☐	☒

Was a check completed through the Staff Exclusion List? Date:	☐	☐	☐	☒

Additional information, if necessary:
The SC was the only child placed in the foster home. The BM did not comply with any arranged services after the SC's death and was unable to be reached.

Foster Care Placement History

An SCR report was received on 09/18/2024, upon the birth of the SC with allegations of IG ad PD/AM against the SM for the SC. The SC was born with positive toxicology for cocaine and heroin. The SM reported that 7 previous children were born with positive toxicology and subsequently removed or were voluntarily placed in adoptive homes. The siblings were all freed for adoption or adopted at the time of the fatal incident. The agency held a child safety conference on 9/18/24, where the decision was court involvement. The agency filed an article 10 neglect petition in Kings County family court. The court granted the remand of the SC, and the SC was placed under the care of ACS. The court requested that the agency explore family resources for placement. The SM provided the maternal cousin as a family resource that could care for the SC, and she later became the FM. The FM was explored as a kinship resource for the SC and investigative clearances had been completed. The FM had no ACS or criminal history. ACS conducted a home visit to the FM's home and her home was suitable and could accommodate the SC. There were no safety or health concerns in her home and the SC was placed with the FM upon discharge from the hospital on 11/07/2024. There were no other children in the home. The SC remained in the FM's care until the SC's death. The case closed on 01/09/2025

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:**
09/18/2024	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	070728 Mother Female 33 Year(s)	
Comments:		

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