Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-109

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

Issue Date: Mar 11, 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: 3 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 11/27/2024
Initial Date OCFS Notified: 11/27/2024

Presenting Information

Three SCR reports were received on 11/27/24 alleging that on that date, around 7:00AM, the aunt entered the mother's bedroom where the mother and subject child were sleeping and brought the child to her bedroom and fell asleep with the child in the bed. At 11:00AM, the mother went into the aunt's bedroom and told the aunt to cover the child with a blanket. Around 11:30AM, the child was observed by the aunt's paramour to be blue and unresponsive. The paramour woke the mother and aunt and called 911 at 1:08PM. Cardiopulmonary resuscitation (CPR) was performed until emergency medical services (EMS) arrived. The child was transported to the hospital where she was pronounced deceased. One report alleged the child was in the care of a different aunt, placed on a king-sized bed with blankets and pillows, and not checked on for nine hours prior to being found unresponsive around 1:00PM by an aunt.

Executive Summary

This report concerns the death of the 3-month-old female subject child. The Administration for Children's Services (ACS) received three SCR reports regarding the child's death on 11/27/24. At the time of the child's death, she resided with her mother and father; however, on the day of her death, the child and mother were visiting the maternal grandmother's home. There was some discrepancy in the record as to which residence was considered the child's primary residence.

On 11/27/24, around 5:00 or 6:00AM, the child went to sleep. The child was in the bed with a maternal aunt, and had been placed on her left side, in the middle of the bed, while the aunt slept at the edge of the bed. Around 7:00AM, the aunt heard the child crying and around 11:00 or 11:30AM, the mother awoke, and woke the aunt, telling her to place a blanket over the child. The mother returned to her room and went back to sleep. Around 1:00PM, the aunt's paramour arrived at the home and observed the child on the bed; her lips were purple, and her skin appeared discolored. The paramour yelled, waking the aunt, and called 911 immediately, at 1:08PM. Dispatch provided CPR instruction, and the paramour completed chest compressions while the aunt did rescue breaths to the child's mouth and nose. Upon arrival (reportedly 1:25PM, 1:30PM, or 1:35PM), EMS took over and transported the child to the hospital. The child was in cardiac arrest, unresponsive, and cold. The child was pronounced deceased at 1:49PM, minutes after arrival.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation closed. Discussions with the medical examiner investigator, law enforcement, and hospital staff revealed no suspicious marks or bruises were observed on the child. Supervisory notes reflected the medical examiner reported preliminary findings of "no foul play nor any evidence of abuse or maltreatment but that co-sleeping was noted." No criminal charges were sought in relation to the death.

ACS attempted home visits and interviews; however, the family was mostly uncooperative.

ACS substantiated the allegations of Inadequate Guardianship and Lack of Supervision against the mother and aunt. The mother failed to ensure the child had appropriate sleeping arrangements when visiting the grandmother's home and was aware the child was bed sharing with the aunt. The aunt placed the child in bed with her, rather than in a safe sleep environment. ACS did not describe evidence to support the allegation of Lack of Supervision. Multiple progress notes indicated ACS spoke to the medical examiner, and while "no evidence of foul play" was found, co-sleeping was a factor noted by the medical examiner. ACS relied solely on "no foul play" to unsubstantiate DOA/Fatality. Officials outside the

child welfare system use terminology that is not consistent with CPS, as their terms have meanings and implications different than they do in child welfare. Criminal charges or accidental death does not in and of itself mean that there was not maltreatment in a CPS case. Law enforcement's standard of evidence is higher than that of CPS and should not control CPS's decision as to whether there is a fair preponderance of evidence to substantiate allegations. ACS offered no other support to unsubstantiate the allegation. All allegations were unsubstantiated against the other maternal aunt listed on the report as she was not home at the time of the incident.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The decision to indicate the investigation was appropriate.

Was the decision to close the case appropriate? Yes

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:
Casework activity was not commensurate with regulatory requirements as one subject of the investigation was not interviewed (nor attempts documented). The Risk Assessment Profile, though not required in this case, indicated the death was due to abuse/maltreatment by a caretaker despite the allegation of DOA/Fatality being unsubstantiated.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	There was an aunt listed as a subject in the investigation; however, she was not interviewed, nor were attempts documented to interview the aunt prior to making a determination of the allegations pertaining to her.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full child protective investigation must include face-to-face interviews with subjects of the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/27/2024 **Time of Death:** 01:49 PM

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: 01:08 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	Aunt/Uncle	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

Other Household 1	Father	No Role	Male	45 Year(s)

LDSS Response

On 11/27/24, ACS received three reports regarding the death of the subject child. ACS initiated their investigation within 24 hours and began gathering information. The sources of the reports were contacted, though one source did not avail themselves. ACS completed a CPS history check regarding the family and informed the DA of the fatality. An initial home visit to the grandmother's home where the fatality occurred was completed on 11/29/24. There were differing accounts on if the mother and child resided at the grandmother's or father's residence. The father did not allow ACS to assess his residence. There were no additional children residing at either residence.

The family was uncooperative with interviews. ACS was unable to interview the adults present for the fatal incident separately. Much of the timeline of events was confirmed by collateral sources. The mother reported going out the night prior to the fatality and the child was sleeping with the grandmother. The grandmother fed the child a bottle and left the home around 5:00AM the morning of 11/27/24, at which point the child was reportedly in the bed with the aunt. The aunt recalled hearing the child cry around 7:00AM and then was awoken around 11-11:30AM by the mother telling her to put the blanket over the child. The medical examiner investigator (MEI) stated the blanket was a comforter, not child sized. The MEI also reported there was a portable "crib/bassinet;" however, the child frequently slept in the bed. According to the MEI, no one was able to recall if the child was fed again since 5:00AM. At 1:00PM the aunt's paramour arrived at the home and found the child in the bed and her lips were purple. The aunt woke up at that time, the paramour called 911, and both the aunt and paramour did CPR as directed by 911 dispatch. The mother came out of her room at that point and became hysterical.

There were conflicting accounts of whether a crib or bassinet was available to the child at the grandmother's house. It was not noted in the record that one was observed during the home visit. The father reported there was one available at his house but denied one was available at the grandmother's house. Following the initial contact, the family declined further involvement with ACS and did not sign releases.

The MEI reported to ACS no suspicious marks to the child, and no evidence the child rolled off the bed, the only concern at that point was co-sleeping. Hospital staff reported upon arrival the child was already stiff, cold, and rigor mortis had set in. They confirmed no suspicious marks or bruises but declined to comment on the relationship between the sleep environment and death. Supervisory progress notes reflect the ME was spoken to and informed ACS the preliminary finding found no foul play but "co-sleeping was noted as a factor." Final autopsy report results were not available and could take months. Law enforcement did not pursue criminal charges. The family declined fatality-related services and did not wish to have further ACS involvement. There were no additional children residing in either household, the report was indicated due to the substantiation of Inadequate Guardianship and Lack of Supervision, and appropriately 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 OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070134 - Deceased Child, Female, 3 Month(s)	070135 - Mother, Female, 24 Year(s)	Lack of Supervision	Substantiated
070134 - Deceased Child, Female, 3 Month(s)	070137 - Aunt/Uncle, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
070134 - Deceased Child, Female, 3 Month(s)	070135 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
070134 - Deceased Child, Female, 3 Month(s)	070135 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
070134 - Deceased Child, Female, 3 Month(s)	070137 - Aunt/Uncle, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
070134 - Deceased Child, Female, 3 Month(s)	070137 - Aunt/Uncle, Female, 29 Year(s)	Lack of Supervision	Substantiated
070134 - Deceased Child, Female, 3 Month(s)	070139 - Aunt/Uncle, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
070134 - Deceased Child, Female, 3 Month(s)	070139 - Aunt/Uncle, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
070134 - Deceased Child, Female, 3 Month(s)	070139 - Aunt/Uncle, Female, 24 Year(s)	Lack of Supervision	Unsubstantiated

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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

An aunt listed as a subject was not interviewed. The father did not avail himself to be interviewed face-to-face, though was not a subject of the report. The family was uncooperative with signing releases for collateral contact.

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	☐	☐	☐	☐	☐	☒

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:

Bereavement services and funeral assistance were offered to the family, and they declined.

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 known 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