Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-124

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: 10 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 12/28/2024
Initial Date OCFS Notified: 12/28/2024

Presenting Information

An SCR report was received on 12/28/24, which stated the subject mother placed the 10-month-old subject child and his twin sibling to sleep in the bed with her. At some point, the subject father heard the surviving sibling crying and brought him into the living room. At approximately 7:30PM, the subject mother woke up and found the subject child unresponsive with a blanket wrapped around his body. The subject father was immediately alerted and dialed 911. EMS arrived and performed life saving measures, but the subject child remained unresponsive. EMS transported the subject child to the hospital where the subject child was pronounced deceased.

Executive Summary

This report concerns the death of a 10-month-old male child. New York City Administration for Children's Services (ACS) received an SCR report regarding the child's death on 12/28/24. At the time of the child's death, he resided with his twin sibling, mother, father and paternal uncle.

According to the family, at approximately 4:00pm on 12/28/24, the subject mother took a nap on her bed with the twins beside her. Sometime around 5:00pm, the subject father heard the surviving sibling crying so he took him into the living room so he would not wake the subject mother and the subject child. The subject father stated at that time, he observed the subject child was laying on the end of the bed with nothing obstructing him. Sometime between 6:00pm and 6:30pm, the subject mother awoke and went into the living room looking for the children. The subject father informed her that he only took the surviving sibling out of the bed, leaving the subject child in bed with her. She then ran back to the bedroom and observed the subject child entangled in a blanket on the end of the bed with only his foot exposed. The child was blue and not breathing so the subject father began CPR while the paternal uncle called 911. Lifesaving measures were performed by the responding Emergency Medical Technician's (EMT) and hospital staff but were unsuccessful. The child was pronounced deceased at 8:24pm.

ACS appropriately spoke with collateral contacts. The medical examiner stated the preliminary results of the autopsy showed no signs of foul play. Law enforcement assigned to the case stated they did not suspect any foul play and no arrests were made. The doctor who provided care to the subject child at the hospital stated that from her clinical experience, she believes the subject mother accidently rolled onto the subject child and suffocated him while sleeping because a 10-month-old is typically able to move a blanket from their face.

The allegation of DOA/fatality against the subject mother for the subject child was substantiated. During the investigation the subject mother acknowledged bed-sharing with both children regularly. The subject mother also reported that the subject child would cry for her adult sized blanket, and she would give it to him to comfort him. The subject child was found entangled in the blanket during the fatal incident. The doctor who provided care to the subject child at the hospital stated that from her clinical experience, she believes the subject mother accidently rolled onto the subject child and suffocated him while sleeping.

The allegation of DOA/fatality against the subject father for the subject child was substantiated. During the investigation, the subject father confirmed that he was aware of safe sleep practices but placed the subject child in immediate or impending danger by utilizing and allowing him to remain in an unsafe sleep environment.

The allegation of inadequate guardianship against both parents for the subject child and his surviving sibling were substantiated. Both parents reported that they regularly bed-shared with both children on an adult sized bed with blankets, sheets and pillows, placing the children in immediate or impending danger by utilizing an unsafe sleep environment.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Was the decision to close the case appropriate? 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 decision to close the case was appropriate. Safe sleep practices were discussed and implemented for the surviving sibling. The surviving sibling was deemed safe in the care of his parents.

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

Child Fatality Report

Date of Death: 12/28/2024 **Time of Death:** 08:28 PM

Time of fatal incident, if different than time of death: 06:00 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 07:31 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	Aunt/Uncle	No Role	Male	34 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	10 Month(s)

LDSS Response

On 12/28/24, an SCR report was received regarding the death of a 10-month-old male subject child. ACS initiated their investigation within 24 hours, contacted the source of the report, notified the district attorney, communicated with the medical examiner, EMT and law enforcement and completed a CPS history review.

ACS completed a thorough home visit and interviewed both parents. The subject mother stated at approximately 4:00pm on 12/28/24, she placed the twins on her queen-sized bed and laid down next to them to take a nap. She stated she was very tired because the twins refused to sleep the night before and were awake until approximately 7:00am. She stated when she fell asleep the twins were awake playing and watching television on her bed. At approximately 6:30pm she awoke but did not see the twins on the bed any longer. She then went into the living room and observed the surviving sibling with the subject father. The subject father informed her that he did not have the subject child with him. She then ran back into the bedroom where she observed the subject child on the bed, wrapped in a blanket with only his foot exposed. She stated she unwrapped him and discovered he was blue in color and not breathing. She then began to yell; the subject father entered

the room and began CPR while his brother called 911.

The subject father stated it was a regular day for the family, the only difference being the twins refused to go to sleep the night before and were up all night playing and watching television. He stated they do that occasionally, but not regularly. He stated that at approximately 4:00pm, the twins and the subject mother went into their room to take a nap. At approximately 5:00pm he heard the surviving sibling crying so he went into the bedroom to get him. He stated he observed the subject mother and subject child asleep on the bed at that time. Sometime between 6:00pm and 6:30pm, the subject mother came into the living room asking for the twins. When she did not see the subject child, she returned to the bedroom where she found him on the bed wrapped in a blanket. She began screaming, he ran in and began CPR while his brother called 911. He stated the ambulance arrived within 15 minutes and brought them to the hospital, where the subject child was pronounced deceased.

ACS interviewed the paternal uncle who also resided in the home. He stated he did not have any childcare responsibility in the home. He stated he typically stayed in his own area of the home, so he had no knowledge of the incident except that he heard screaming and called 911 because the subject child was not breathing.

During the initial home visit, ACS observed a queen-sized bed with many pillows and blankets in their bedroom. Next to the bed was a bassinet filled with clothing and baby supplies. Both parents admitted that they were aware of safe sleep recommendations but had always bed shared with the twins. ACS assisted them with removing the items from the bassinet and placing a fitted sheet inside for the surviving sibling. ACS also provided the family with a smoke/carbon monoxide detector because the one in the home was not working properly.

During the investigation, ACS assisted with burial planning, provided grief counseling information, made an early intervention referral and provided a pack and play for the surviving sibling due to him beginning to outgrow his bassinet. Safe sleep recommendations for the surviving sibling were discussed with the family repeatedly throughout the investigation.

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: NYC does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070350 - Deceased Child, Male, 10 Month(s)	070352 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated

070350 - Deceased Child, Male, 10 Month(s)	070352 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
070350 - Deceased Child, Male, 10 Month(s)	070353 - Father, Male, 40 Year(s)	DOA / Fatality	Substantiated
070350 - Deceased Child, Male, 10 Month(s)	070353 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
070351 - Sibling, Male, 10 Month(s)	070353 - Father, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
070351 - Sibling, Male, 10 Month(s)	070352 - Mother, Female, 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:
The family participated in grief counseling services

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	☐	☐	☐	☐	☐	☒

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? N/A
Explain:
The surviving sibling is an infant.

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 family met with a grief counselor in their home.

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

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