Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-001

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: 3 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 01/01/2023
Initial Date OCFS Notified: 01/01/2023

Presenting Information

An SCR report alleged on 1/1/23, the grandmother was the sole caretaker to the three-month-old subject child. At some point during the day the grandmother laid down to take a nap and placed the child facedown on his stomach next to her in the bed. The grandmother woke up and found the child unresponsive. Emergency Medical Services were called, and the child was brought to the hospital where he was pronounced deceased. It was believed that an unsafe sleep situation contributed to the child's death. The roles of the mother and father were unknown.

Executive Summary

On 1/1/23, New York City Administration for Children's Services (ACS) received an SCR report regarding the death of the 3-month-old male subject child that occurred on the same day. The child resided with his mother and father. The child was with the paternal grandmother for an overnight visit. There were no surviving siblings, and the paternal grandmother had no other children in her home.

ACS coordinated investigative efforts with law enforcement and learned the child was dropped off by the father to the paternal grandmother for an overnight visit on 12/31/22, around 11:30PM. The paternal grandmother and the child went to a relative's home in the same building and returned home sometime between 1:00AM and 2:00AM on 1/1/23. At about 4:30AM the paternal grandmother changed the child's diaper and took a picture of him. After the diaper change, the paternal grandmother laid the child down on a blanket, on her bed, in the prone position; although, there was a travelling bassinet in the room. The paternal grandmother laid down next to the child and fell asleep. When the paternal grandmother awoke sometime around 2:00PM, the child was found facedown not breathing and had a purple mark on his forehead. The paternal grandmother took the child to the paternal great grandmother's apartment on the second floor of the building. The paternal great uncle called 911 and performed cardiopulmonary resuscitation as instructed by the 911 dispatcher until emergency services arrived, took over resuscitative measures, and transported the child to the hospital. Hospital staff continued life saving measures; however, were unsuccessful and the child was pronounced deceased at 3:20PM.

An autopsy was performed; however, the final autopsy report was pending at the time this report was written. ACS spoke with the medical examiner and learned the child had "Patent Fossa Ovalis of the heart"; however, further testing was needed to determine if this condition contributed to the child's death. The record did not reflect if ACS had a conversation about safe sleep being a contributing factor to the child's death. ACS observed photos of the re-enactment that was done by law enforcement and the medical examiner. Law enforcement found no criminality and closed their investigation. The case would be re-opened if something was revealed in the final autopsy report.

ACS substantiated the allegation of Inadequate Guardianship against the paternal grandmother regarding the child. ACS determined the paternal grandmother failed to provide the child a safe sleep environment when she placed the child in the prone position on an adult bed and co-slept with the child. The paternal grandmother had a traveling bassinet that was provided by the parents for the child to sleep in and was told by the parents to place the child on his back in the bassinet to sleep. The allegation of DOA/Fatality was unsubstantiated against the paternal grandmother regarding the child. ACS determined there was not a fair preponderance of evidence to support the paternal grandmother failed to provide a reasonable minimum degree of care for the child.

ACS offered the parents burial assistance, and they accepted. Bereavement counseling was offered to the parents, paternal grandmother, paternal great uncle, and paternal great grandmother, which they declined. ACS provided the family with

community-based resources, and the parents were engaged in bereavement services at the close of the investigation. The case was indicated and closed on 3/2/23.

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?** 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?** No

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 the case circumstance the DOA/Fatality allegation was incorrectly unsubstantiated.

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: 01/01/2023 **Time of Death:** 03:20 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: 02:46 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	3 Month(s)
Deceased Child's Household	Father	No Role	Male	37 Year(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	57 Year(s)

LDSS Response

On 1/1/23, ACS received a report regarding the death of the SC. 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, and informed the DA of the fatality. ACS made home visits and met with the PGM, the parents, and interviewed relatives. ACS contacted the ME; however, the record did not reflect ACS asked about safe sleep being a contributing factor in the SC's death.

ACS completed collateral and casework contacts and learned the parents brought the child to the PGM's apartment around 11:15PM on 12/31/22. The father brought a traveling bassinet for the SC to sleep in while at the PGM's home. The father made the PGM aware of the safe sleep recommendations and told her to place the SC on his back in the bassinet to sleep. The parents left the PGM's home around 11:45PM. The PGM had watched the SC several times prior to his death while the parents ran errands, and the parents had no concerns for the PGM's care of the SC. The mother texted the PGM at about 9:55AM on 1/1/23, and she got no response from the PGM. The father got a call around 2:48PM, from the PGM, that the SC was not breathing and was in the ambulance going to the hospital.

The investigation revealed after the father dropped the SC at the PGM's home, the PGM and the SC went to the PGGM's home, in the same building. The PGM denied she consumed any alcohol while caring for the SC. The PGM and SC returned to her apartment sometime between 1:00AM and 2:00AM on 1/1/23. When she returned home, she fed the SC 4 ounces of formula, burped the SC, and stayed up for a few hours. At about 4:30AM the PGM changed the SC's diaper and took a picture of him. The PGM laid the SC in the prone position, on a blanket, horizontally on her adult bed to sleep; although, the traveling bassinet was in the room for the SC. The PGM laid down horizontally next to the SC and fell asleep. The PGM awoke sometime around 2:00PM, found the SC on his stomach with his face in the mattress, and he was unresponsive. She picked the SC up, lifted his eyelid and it immediately closed. The PGM said she panicked and did not know what to do. She took the SC and went to the PGGM's home, two floors down, and the PGGM called the paternal great uncle. The paternal great uncle arrived at the apartment, called 911 at about 2:46PM, and performed CPR as directed by the 911 operator until EMS arrived.

ACS contacted several collateral sources including LE, hospital staff, EMS, the pediatrician, several neighbors, and

relatives. ACS observed photos taken at the PGM's home during the re-enactment of how the SC was placed on the bed by the PGM. Hospital staff reported upon arrival the SC had lividity on the forehead, right shoulder, and heel; an indicator the SC was likely deceased prior to his arrival at the hospital. ACS interviewed the PGGM, and she had no concerns for the PGM, or her care of the SC. The paternal great uncle had no information regarding the events that led to the fatal incident. The record reflected the PGM was engaged in a substance abuse treatment program and had difficulty maintaining her sobriety. ACS spoke with relatives and found no evidence the PGM was under the influence of any substances while caring for the SC.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063613 - Deceased Child, Male, 3 Mons	063616 - Grandparent, Female, 57 Year(s)	DOA / Fatality	Unsubstantiated
063613 - Deceased Child, Male, 3 Mons	063616 - Grandparent, Female, 57 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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
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	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The PGM was engaged in substance abuse treatment prior to the death and refused services offered by ACS. ACS offered the mother DV services, and she declined. The parents engaged in community-based grief counseling prior to the

CPS case closing.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS offered burial assistance to the parents, and they accepted. The PGM, PGGM, and PU were offered bereavement services, and they declined. The parents were enrolled in community-based counseling services at the close of the investigation.

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