Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-069

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

Issue Date: Dec 06, 2023

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: Kings
Gender: Male
Date of Death: 07/07/2023
Initial Date OCFS Notified: 07/07/2023

Presenting Information

An SCR report was received on 7/7/23 alleging on that same date, around 12:05PM, the grandmother placed the 3-month-old child in a crib with a pillow to sleep in an unknown manner. The grandmother checked on the child at approximately 2:00PM and found him unresponsive and not breathing on his stomach. The grandmother immediately called 911. It is unknown if the grandmother performed cardiopulmonary resuscitation on the child. Emergency medical services responded to the home and transported the child to the hospital at 2:05PM. While at the hospital, life-saving measures were attempted yet unsuccessful. The child was pronounced deceased at 2:35PM. The unsafe sleeping arrangement contributed to the child's death.

Executive Summary

This report concerns the death of a 3-month-old male subject child that occurred on 7/7/23. The New York City Administration for Children's Services (ACS) received an SCR report on 7/7/23, regarding the fatality. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the paternal grandmother. At the time of his death, the subject child resided with his mother and paternal grandmother. The biological father was residing in another state; however, visited the mother and child and assisted them financially. ACS immediately initiated their investigation and learned there were no surviving siblings.

Through a joint investigation with law enforcement, it was learned on 7/7/23, the paternal grandmother was caring for the child while the mother worked. In the early morning, the grandmother fed the child and played with him. A few hours later, the grandmother fed the child again and prepared him for his afternoon nap. The child was placed on the grandmother's bed where she co-slept with him. Around 1:30PM, the paternal grandmother woke and observed the child face-down in the bed, not breathing and his color was bluish/gray. The grandmother contacted a family member who then called 911. Emergency medical services arrived and attempted life-saving measures. The child was transported to the hospital where he was pronounced deceased at 2:35PM.

ACS communicated with the medical examiner's office and learned a preliminary autopsy was completed on 7/8/23 that indicated the 3-month-old child was accidentally smothered while sleeping with the paternal grandmother. There were no other concerns noted in the report for the child. At the time this report was written, the final autopsy report was still pending results from toxicology and blood cultures as well as the retrieval of records.

ACS communicated with the district attorney's office regarding the status of their investigation. ACS learned the assistant district attorney closed their investigation as no evidence of criminality was found. ACS made sufficient attempts to contact law enforcement regarding the status of their case; however, law enforcement did not respond to their numerous attempts.

ACS appropriately substantiated the allegations of DOA/Fatality and Inadequate Guardianship against the paternal grandmother. The record reflected the safety assessments were completed timely and accurately. The risk assessment profile was inaccurate and did not reflect the death was the result of abuse or maltreatment in the elevated risk section of the tool. Progress notes were entered contemporaneously, and all required notices were provided. Investigative actions were not reflective of case circumstances and showed each child residing in the household was interviewed; however, the subject child was deceased and there were no other children involved with the investigation. Furthermore, yes was selected for consulted office of legal affairs when denied entry to the household but is not applicable to the investigation.

ACS spoke with numerous family collaterals and neighbors regarding the fatality and utilized interpreter services to assist with any language barriers. ACS conducted a family team meeting with the parents and provided education surrounding safe sleep practices.

ACS offered the family bereavement services and burial assistance; however, the family declined. ACS gathered pertinent information from collateral contacts such as the child's pediatrician, medical staff, law enforcement, the district attorney, and medical examiner offices.

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:
ACS made an appropriate decision to substantiate the allegations based on evidence obtained throughout their investigation.

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:
Casework activity was commensurate with case circumstances.

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: 07/07/2023 **Time of Death:** 02:35 PM

Time of fatal incident, if different than time of death: 12:30 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	59 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)

LDSS Response

On 7/7/23, ACS received a report regarding the death of the SC. ACS initiated their investigation within 24 hours, contacted the source of the report and completed a CPS history check. ACS notified the district attorney, the medical examiner and coordinated their efforts with law enforcement.

ACS completed an interview with the mother at a relative's residence on 7/7/23. During her interview, she described the evening prior to the fatality as normal with feedings and playing. She gave the SC to the PGM for the evening on 7/6/23, between 8:00 and 10:00PM and heard the PGM laughing and playing with the SC. On 7/7/23, the mother left for work at 5:30AM, she did not check on the SC or speak to the PGM as they were sleeping in the PGM's bedroom. Around 2:00PM, the mother was getting ready to leave work when a co-worker called and told her the SC was not breathing and they needed to contact 911. The mother attempted to call the PGM with no success and then contacted a relative and asked them to go to the home. The relative arrived at the home and learned the SC was transported to the hospital. The mother spoke to EMS who instructed her to go to the hospital. A co-worker drove the mother to the hospital where she was told the SC was pronounced deceased. The mother noted being aware of safe sleep practices, she denied having a crib or Pack 'N Play and explained the SC slept best on his stomach and the family would co-sleep. The mother denied any medical concerns for the SC or that he was showing any symptoms of being ill.

ACS completed an interview with the PGM at her residence on 7/11/23. During her interview, she reported on 7/7/23, the mother left for work at 5:30AM and at that same time, the SC woke. The PGM explained she prepared the SC's bottle of formula, fed, burped, and then played with him. At 8:30AM and 11:30AM she fed the SC his formula and began getting

him ready for his 12:00PM nap. The PGM reported the SC took longer to fall asleep than normal and went down at 12:30PM. She placed the SC face-down on the left side of her bed with his face positioned toward the right side of the bed. When asked if she used blankets or pillows, the PGM explained she used a sheet under the SC for cushioning and placed a blanket over his back to keep the SC warm as she had the air conditioner running. In addition, she reported placing a pillow on the edge of the left side of the bed and then she laid down on the right side of the bed. At approximately 1:30PM, the PGM received a phone call and woke from the noise; she then observed the SC face-down on the bed that they shared. The PGM turned the SC around and noticed he was not breathing, his skin color was pale, and his lips were bluish grey. She explained she shook the SC's body because she thought his condition would change. Around 1:45PM, the PGM called a relative and explained the condition of the SC, the relative contacted the mother's co-worker. The mother's co-worker then contacted 911. The PGM attempted CPR until the ambulance arrived and transported the SC to the hospital.

ACS interviewed the father via telephone and in person on 7/11/23. The father confirmed he was residing in another state at the time of the fatality. On 7/7/23, the father explained he received a frantic phone call from the PGM regarding the SC. He reported the PGM stated she woke up and found the SC unresponsive and he was transported to the hospital. The mother also contacted the father and informed him that the SC was deceased. There was no additional information provided regarding the fatality.

ACS spoke with EMS and learned there was a white liquid in the child's airway that was suctioned. Upon EMS's arrival, the child was cool to the touch and his extremities were bluish grey in color. ACS spoke with staff at the SC's pediatrician's office, there were no medical concerns noted for the SC and his immunizations.

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: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065328 - Deceased Child, Male, 3 Month(s)	065330 - Grandparent, Female, 59 Year(s)	DOA / Fatality	Substantiated
065328 - Deceased Child, Male, 3 Month(s)	065330 - Grandparent, Female, 59 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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was offered bereavement services and burial assistance; however, 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