Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-019

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

Issue Date: Nov 15, 2021

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 has an open 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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 05/20/2021
Initial Date OCFS Notified: 05/20/2021

Presenting Information

An SCR report was received which alleged that on 5/20/21, the unrelated caregiver of the three-month-old subject child laid the child down to sleep, and some time later, found him unresponsive. The caregiver called emergency services and began performing cardiopulmonary resuscitation. When the ambulance arrived, the child was intubated and taken to the hospital, where he was pronounced dead. The child had no visible injuries, and there was no explanation for his death. The roles of his mother and father were unknown.

Executive Summary

This fatality report concerns the death of a three-month-old subject child that occurred on 5/20/21. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's caregiver (CG) and the caregiver's husband. Suffolk County Department of Social Services (SCDSS) received the report and investigated the child's death. An autopsy was completed; however, the final report had not yet been released at the time of this writing. Therefore, the cause and manner of death remained pending.

At the time of the child's death, the child and his four-year-old sibling were at the caregiver's residence, as the caregiver was babysitting for the children's parents. Also residing in the caregiver's home was her husband, their 17-year-old child, and the caregiver's mother and father. The investigation revealed that at approximately 3PM on 5/20/21, the caregiver was with the subject child and sibling while they watched television in the family room until they became tired. The sibling fell asleep on the couch, and the caregiver brought the subject child upstairs to her and her husband's bedroom to nap. The caregiver's husband was asleep in their bed at the time. The caregiver swaddled the child in a blanket and placed him on his side on the adult bed. She then placed a pillow between her husband and the child, who were on opposite sides of the bed. The caregiver then left the room, and reportedly checked on the child frequently. At one point when she looked in on the child, she noticed he looked strange. She found the child to have a pink colored foam coming from his nose, and when she removed the swaddle, she discovered he was not breathing. The caregiver woke her husband who was still in the bed, and emergency services were called. An ambulance responded to the home and transported the child to a local hospital. The caregiver called the child's father and notified him of what occurred. The child could not be revived and was pronounced deceased at 6:07PM on 5/20/21.

From the time the investigation began to the time of its closure, SCDSS assessed the safety of the surviving sibling, as well as the caregiver's child, and no concerns were noted. SCDSS interviewed family members and collateral sources, including law enforcement, the medical examiner, the hospital staff, and the child's pediatrician. Although medical professionals stated there was no physical indication the child was maltreated or abused, evidence revealed the child was put to sleep in an unsafe environment with aggravating factors that placed him at imminent risk of harm. Further, the unsafe sleeping conditions were not fully explored with the child's caregiver: The record did not reflect any information was gathered as to what position the child was in when the caregiver found him unresponsive, what kind of blanket the child was swaddled in, the size of the bed, his proximity to blankets and pillows on the bed, if the caregiver's husband was aware the child was in bed with him, or whether any of the caregivers were aware of safe sleep practices. SCDSS noted there was no evidence found to support the child's death was the result of abuse or neglect; however, without the aforementioned information, it is unclear how SCDSS made that determination. With the information that was available, some credible evidence was gathered to substantiate the caregiver for Inadequate Guardianship, but all allegations in the report were unsubstantiated and the case was closed.

PIP Requirement

This review resulted in citations related to casework practice. In response, SCDSS will submit a PIP to their Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the SCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, SCDSS will review the plan(s) and revise as needed.

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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:

The record did not reflect all key information regarding the circumstances of the child's death were ascertained. This included the position of the child when found unresponsive, his proximity to items in the bed, what he was swaddled in, if the caregiver's husband was aware the child was put to sleep in bed with him, and if the caregivers were aware of safe sleep practices.

Was the decision to close the case appropriate? Unknown

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:

The sibling and caregiver's child were assessed as safe, and the case record reflected supervisory consultations throughout the investigation. SCDSS did not gather all available information regarding the circumstances surrounding the child's death.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The record reflected some credible evidence was gathered to substantiate the caregiver for Inadequate Guardianship; however, SCDSS unsubstantiated the allegation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	SCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).
Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	The record did not reflect all key information surrounding the death of the child was gathered.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/20/2021 **Time of Death:** 06:10 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 05:07 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 20 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ 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	38 Year(s)
Deceased Child's Household	Mother	No Role	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Other Household 1	Other - Caregiver (CG)	Alleged Perpetrator	Female	40 Year(s)
Other Household 1	Other - Caregiver's Husband	Alleged Perpetrator	Male	42 Year(s)
Other Household 1	Other - Caregiver's Mother	Alleged Perpetrator	Female	74 Year(s)
Other Household 1	Other - Caregiver's Father	Alleged Perpetrator	Male	82 Year(s)
Other Household 1	Other Child - Caregiver's Child	No Role	Male	17 Year(s)

LDSS Response

On 5/20/21, SCDSS received the SCR report regarding the death of SC, which occurred on that same date. SCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. SCDSS learned there was one SS and worked promptly to assess his safety.

On 5/21/21, SCDSS met with the parents at their home. BM declined to speak with SCDSS at that time; however, BF agreed to be interviewed. BF explained BM was out of town for work yesterday, and he went to play golf, so both CHN went to CG's home for the day. BF stated while out, he received a call from CG screaming that SC was not breathing. BF reported he went straight to the hospital. He provided no further information surrounding the incident.

On this same date, SCDSS met with CG and her family at their home. CG resided with her husband, her mother and father, and her two children (20yo and 17yo). CG explained only she provided care to SC and SS, and on the afternoon of 5/20/21, she was babysitting both CHN at her home. CG stated both CHN were watching television in the living room and eventually, SS became tired and fell asleep on the couch. CG stated she then brought SC upstairs to her and her husband's bedroom for a nap. CG said she swaddled SC in a blanket, gave him a pacifier, and placed him on her and her husband's bed. CG explained she placed him on his side, as is what she typically did. She explained her husband was also in the same bed asleep on the opposite side of SC. CG stated she placed a pillow in the center of the bed between SC and her husband. CG reported she then left the room but checked on SC approximately every 20 minutes. CG explained she did not recall how long SC had been asleep, but at one point when she checked on him, he looked "weird." CG said SC had foam coming out of his nose, so she removed the swaddle and discovered he was not breathing. She stated she woke up her husband and called 911, who instructed them how to perform CPR. CG said the ambulance took SC and later, LE went to the house to inform her SC had died. CG stated she had been watching both CHN since they were born and had a close relationship with BM and BF. CG denied SC was showing any signs of illness or distress during the time she was caring for him the previous day. She stated he was fussy, but thought it was due to him needing a nap. CG had no further information surrounding the incident. SCDSS assessed the safety of the 17yo CH in the home and noted no concerns.

On 6/22/21, SCDSS returned to CG's home to interview the other family members. All denied any concerns regarding SC leading up to his death and had no new or additional information regarding the incident.

On 6/30/21, SCDSS conducted a home visit to BM and BF's residence. SS was present and assessed as safe; he would not engage in an interview. BM stated she could not talk about the day SC died, but explained she had spoken with numerous doctors she knew, not involved with the case, who informed her SC's death was an unexplained phenomenon; however, there was no evidence provided to BM or SCDSS to verify this.

Throughout the investigation, SCDSS assessed the safety of the SS on several occasions and spoke with collateral sources. LE completed a reenactment with CG and her husband and found their explanation consistent with such. LE also noted there were blankets on the bed, and SC was on the opposite side of the bed from CG's husband, but no additional information was provided. Further, statements obtained by LE corroborated information gathered during SCDSS' interviews with SC and CG's families. There were no criminal charges brought against any of the caregivers. SCDSS offered the families services in response to the fatality, which were declined, as community supports were being utilized. SCDSS concluded there was no evidence of abuse or maltreatment and unfounded and closed the case.

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
Comments: This fatality investigation was conducted by the Suffolk County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Suffolk County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058652 - Deceased Child, Male, 3 Mons	058656 - Other - Caregiver (CG), Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
058652 - Deceased Child, Male, 3 Mons	058656 - Other - Caregiver (CG), Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
058652 - Deceased Child, Male, 3 Mons	058657 - Other - Caregiver's Husband, Male, 42 Year(s)	DOA / Fatality	Unsubstantiated
058652 - Deceased Child, Male, 3 Mons	058657 - Other - Caregiver's Husband, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
058652 - Deceased Child, Male, 3 Mons	058658 - Other - Caregiver's Mother, Female, 74 Year(s)	DOA / Fatality	Unsubstantiated
058652 - Deceased Child, Male, 3 Mons	058658 - Other - Caregiver's Mother, Female, 74 Year(s)	Inadequate Guardianship	Unsubstantiated
058652 - Deceased Child, Male, 3 Mons	058659 - Other - Caregiver's Father, Male, 82 Year(s)	DOA / Fatality	Unsubstantiated
058652 - Deceased Child, Male, 3 Mons	058659 - Other - Caregiver's Father, Male, 82 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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:

SCDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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: SCDSS offered the family services in response to the child's death.				

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The surviving sibling and caregiver's child were assessed as safe and did not need to be removed as a result of this fatality report.				

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:
SCDSS offered the families services in response to the fatality; however, they were declined. The families were engaged in services within their communities at the time the investigation was closed.

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? Yes
Explain:
Service referrals were provided to the families for the sibling and caregiver's child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Service referrals for grief and bereavement counseling were provided to the families following the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? 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
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:

☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither 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

In 2014, CG and her husband were named as nonconfirmed subjects in one unfounded report with allegations of IG and LS regarding their now 17yo CH.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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