Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-22-043

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

Issue Date: Apr 19, 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: 22 day(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 11/04/2022
Initial Date OCFS Notified: 11/04/2022

Presenting Information

On 11/4/2022, Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the death of the 22-day-old subject child. The report alleged the mother laid down on the adult bed sometime around 12:00 AM on 11/4/2022 to breastfeed the subject child. Sometime prior to 2:00 AM, the father entered the room and observed the child was acting strange and there was blood coming from his nose. The father woke the mother and the parents called 911. The parents were instructed to perform CPR on the subject child. EMS responded to the home and transported the subject child to the hospital where he was pronounced deceased sometime after 2:00 AM. There was a 3-year-old surviving sibling and a 22-day-old surviving twin sibling, both were listed on the SCR report with no role.

Executive Summary

This report regards the death of the 22-day-old subject child which occurred on 11/4/2022. At the time of his death, the subject child resided with his mother, father, 3-year-old surviving sibling, and 22-day-old surviving twin sibling. The surviving siblings were assessed throughout the investigation and determined to be safe in the care of the parents.

The subject child and surviving twin sibling were fed every 3 hours, prompted by an alarm the mother had set on her phone. At 12:00 AM on 11/4/2022, the mother fed the surviving twin sibling, the father returned the surviving sibling to his bassinet, and then brought the subject child to the mother for feeding. The mother was laying on her right side in her bed when she fed the subject child. The father left the bedroom and was in the bathroom for about 20 minutes. As a precaution, the parents had equipped the subject child and surviving twin sibling with devices to monitor their breathing. Upon returning to the bedroom, the father heard an alarm, indicating the subject child was not breathing. The father noticed the subject child was tucked under the subject mother and his nose and mouth were covered by the mother's breast. The father woke the mother, and both noted the subject child was unresponsive and pale. The mother began performing CPR and the father contacted 911. Both parents observed blood and milk coming from the subject child's nose and mouth after the mother began CPR. EMS responded to the home and the subject child was transported to the hospital via ambulance.

First responders noted the subject child was unresponsive and cold to the touch when they arrived at the home. EMS and hospital staff confirmed the subject child was administered CPR at the home, in the ambulance, and at the hospital for about 1 hour before he was pronounced deceased at 2:06 AM.

SCDSS contacted the office of the medical examiner and learned an autopsy was completed 11/4/2022. The medical examiner's office provided preliminary results and stated the trauma and injuries observed during the examination were consistent with the account provided by the parents that the mother was breastfeeding the subject child. The final autopsy report and death certificate were pending toxicology results and were not yet available at the time this report was written. SCDSS coordinated with law enforcement and learned the law enforcement investigation regarding the death of the subject child was closed on 12/5/2022, with no criminal charges or arrests.

The allegations of Inadequate Guardianship and DOA / Fatality were incorrectly determined to be unsubstantiated against the mother by SCDSS. The investigation conclusion narrative noted the allegations were unsubstantiated against the mother and father regarding the subject child and stated there was no evidence found to show that the physical, mental, or emotional condition of the subject child was placed at risk of impairment by the actions of the parents. However, the case record reflected the subject child's physical condition was impaired when the mother fell asleep while breastfeeding the

subject child in an unsafe sleep environment, resulting in her breast covering the subject child's nose and mouth. Furthermore, the preliminary examination results provided by the medical examiner's office noted the trauma and injuries sustained by the subject child were consistent with the parent's account of the mother breastfeeding the child.

The mother engaged with bereavement services and the father declined such services. Service needs were not identified for the surviving siblings. The parents were counseled regarding safe sleep and nursing practices and decided to hire a nurse to stay with the family overnight to care for the surviving twin sibling. The record did not reflect if the parents had received previous safe sleep or safe breast feeding education.

PIP Requirement
SCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS 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:**
  - **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?** 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:
SCDSS gathered information related to the fatality and assessed for the safety of the surviving siblings throughout the investigation. The CPS investigation was closed timely; however, the determination of the allegations against the mother were not consistent with the evidence gathered.

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 evidence gathered supported a fair preponderance; however, the allegations of DOA / Fatality and Inadequate Guardianship were unsubstantiated against the mother.
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 consult with the Westchester Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/04/2022 **Time of Death:** 02:06 AM

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: 01:06 AM
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	22 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Male	22 Day(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

Within 24 hours of receipt of the SCR report on 11/4/2022, SCDSS initiated an investigation, assessed the safety of the surviving siblings, interviewed the mother and father, coordinated with law enforcement, contacted the medical examiner, and gathered information from pertinent collateral sources.

The mother and father were interviewed separately at the family's home and provided similar accounts of the events leading up to the death of the subject child. The subject child and surviving twin sibling were fed at 9:00 PM on 11/3/2022 and the next feeding began at 12:00 AM on 11/4/2022. Per the parents' report, the surviving twin sibling was fed first as he was crying. After the mother fed the surviving twin sibling, she turned to lay on her right side in the parents' bed. The father handed the subject child to the mother and left the room to use the bathroom. The father was gone from the room for about 20 minutes. The mother stated she fed the subject child from her right breast while laying on her right side. The mother stated the subject child was "tucked" next to her and she must have fallen asleep. The subject child and surviving twin sibling were fitted with devices to monitor their breathing, as a precaution. When the father returned to the bedroom, he heard the monitor's alarm and noticed the subject child was tucked under the mother's side and the mother's breast was covering the subject child's nose and mouth. Both parents reported the father called 911 while the mother began CPR. Upon administering CPR, both parents observed blood and milk coming from the subject child's nose and mouth.

SCDSS assessed the family's home throughout the investigation and found it to be safe and appropriate for the surviving siblings. Safe sleep provisions were observed for the surviving twin-sibling. After the death of the subject child, the mother began to utilize a rocking chair at all times when feeding the surviving twin-sibling.

SCDSS gathered information from the children's pediatrician and learned the subject child and surviving siblings were up to date with well visits and the practice had no concerns for the children in the care of the parents.

SCDSS spoke with the mother's bereavement counselor who reported no concerns for the mother's ability to care for the surviving children.

Shortly after the fatality, the parents hired a nurse to stay in the home overnight 5 days per week to help care for the surviving twin sibling. SCDSS spoke with the night nurse who reported no concerns for the parents' ability to care for the surviving siblings. The parents utilized family members to provide the same help on the 2 nights per week the nurse was not at the home.

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
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

062061 - Deceased Child, Male, 22 Days	063133 - Father, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated
062061 - Deceased Child, Male, 22 Days	063132 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
062061 - Deceased Child, Male, 22 Days	063132 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
062061 - Deceased Child, Male, 22 Days	063133 - Father, Male, 34 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?	☒	☐	☐	☐

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 mother was engaged in bereavement services. The father was offered services but declined them. Service needs were not identified for the surviving siblings related to the fatality. The family utilized family resources and a night nurse to help care for the surviving twin sibling overnight.

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?	☐	☒	☐	☐

Explain as necessary:
The mother and father arranged for family members, and eventually a night nurse, to stay at the home overnight to supervise the mother while feeding the surviving twin sibling.

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 mother engaged with bereavement counseling after the death. The father declined a need for counseling. Service needs were not identified for the surviving siblings. Family members were utilized as safety resource after the fatality and multiple family members stayed with the family overnight to help care for the surviving twin-sibling.

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? No
Explain:
Service needs were not identified for the surviving siblings. The siblings were not old enough and did not appear to have experienced trauma related to the death of the subject child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother engaged with bereavement services. The father declined services.

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
- ☐ 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 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.

Additional Local District Comments

Suffolk County DSS does not agree with OCFS determination that this case should have been indicated for Inadequate Guardianship and DOA/Fatality.

It is important to note that the mother was not bed-sharing but feeding her infant in the very early morning hours. The twin who ate earlier was appropriately placed back into the bassinet to sleep. The mother has a 3 yr old surviving sibling and a 2-month-old twin of the surviving sibling. She has had normal experiences with her other two children. She adequately had her husband awake with her to support her in caring for her infants who unfortunately had to use the bathroom during the time of the 2nd child's feeding, a normal human need and after returning in 20 mins found the child to be unresponsive. Furthermore, they had alarms set up for the children in case they stopped breathing, although they did not hear them. There

is no prior history, there are no concerns for drug use, etc. This family has the privilege to hire a nurse to support the mother after the deceased child; this is not something that any parent can do. To OCFS point yes, she was very tired, she is a mother of twins and a 3 yr old, hence why the children's father, her husband, was awake and helping her.

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