Child Fatality Report

Report Identification Number: SV-23-003

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

Issue Date: Jun 23, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)

Jurisdiction: Suffolk
Gender: Male

Date of Death: 01/22/2023
Initial Date OCFS Notified: 01/23/2023

Presenting Information

An SCR report alleged that on 1/21/23 at approximately 10:00 PM the mother went to sleep with the 1-month-old male subject child next to her in her bed. On 1/22/23 at some time prior to 10:06 AM, the mother woke up and found the child unresponsive. The child did not have any visible injuries. The mother did not administer CPR. 911 was called at approximately 10:06 AM. Law enforcement arrived and administered cardiopulmonary resuscitation to the child. Emergency medical services continued life-saving efforts while transporting the child to the hospital. The child arrived at the hospital at 10:26 AM and medical staff continued to attempt to revive the child, but they were unsuccessful. The child was pronounced deceased at 10:51 AM.

Executive Summary

This fatality report is regarding the death of a 1-month-old male child that occurred on 1/22/23. A report was made to the SCR on 1/23/23 and alleged DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child. The child resided with her mother, maternal grandmother, and maternal uncle. The child had no siblings and no other children were residing in the home. The father was incarcerated during the investigation.

Suffolk County Department of Social Services (SCDSS) investigated the death by gathering information from the mother, grandmother, and collateral contacts. It was learned on 1/22/22 at approximately 3:00 AM, the mother fed and burped the child and then placed him to sleep in her queen size bed. The mother placed a border of pillows around the child and laid next to him. The mother fell asleep and woke up between 9:00 and 10:00 AM. The child was not moving and the mother rushed him to the grandmother's room and asked her to call for help. First responders arrived and transported the child to the hospital where he was pronounced deceased at 10:51 AM.

An autopsy was performed and the final results were not yet available at the time the CPS investigation was closed. The autopsy showed that the child had a defect in his heart. The medical examiner reported that while the defect was not necessarily lethal until all pending test results were received a determination on the death could not be provided. There was no evidence of trauma to the child. Law enforcement investigated the fatality and found no criminality regarding the child's death. Law enforcement attended the doll reenactment performed by the medical examiner and reported that based on the preliminary information gathered, they believed the child died from positional asphyxiation.

SCDSS provided the family with information on bereavement and offered funeral assistance. The mother was enrolled in mental health counseling. SCDSS found there was not a fair preponderance of evidence to substantiate the allegations against the mother. The investigation was unfounded and closed on 3/17/23. Through OCFS' review of the record, it was determined that there was a fair preponderance of evidence regarding the allegations. The mother co-slept with the child in an unsafe sleep environment. Following the medical examiner's doll reenactment, law enforcement reported that with the information they had at that time, they believed the death was the result of positional asphyxiation.

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:**
    - **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?** No

Explain:
Though sufficient information was gathered regarding the allegations, the determination made was not supported by the evidence gathered.

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:
Although all other casework activity was commensurate with the case circumstances, the determination was not supported by the information gathered during the investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Though the criteria regarding a fair preponderance of evidence was met with the information documented in the case record, SCDSS did not appropriately determine the investigation.
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: 01/22/2023 **Time of Death:** 10:51 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: 10:06 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
Child's activity at time of incident:

- [x] 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	19 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Other Household 1	Father	No Role	Male	23 Year(s)

LDSS Response

Upon receipt of the SCR report on 1/23/23, SCDSS immediately initiated their investigation, coordinated efforts with law enforcement, notified the medical examiner's and district attorney's offices of the death, completed interviews with the family, and offered appropriate services.

SCDSS interviewed the mother, who reported that on 1/22/23 at approximately 3:00 AM, the mother fed and burped the child and placed him to sleep on his back on her bed. The mother reported she always bundled the child up and kept a border of pillows around him when he slept so he would not move. The mother reported the child fell asleep on top of her arm, and when she woke at approximately 10:00 AM, the child was on his back, and was close to her but not underneath her. The mother noticed the child was not moving, so she rushed him to the grandmother's room. The grandmother called 911 and the child was transported to the hospital by first responders. The mother had a Pack 'n Play, but her bedroom was too small for it so it was placed in the living room. The mother reported it was not common for her to co-sleep with the child and that she normally slept in on the couch and the child in the Pack 'n' Play next to her. The mother denied drug or alcohol use and there were no concerns documented for substance misuse during the investigation.

The grandmother was interviewed and reported on 1/22/23 at 10:00 AM, she was woken up by the mother who said something was wrong with the child. The grandmother noticed the child was not breathing and called 911. The child was

transported to the hospital by emergency medical services and the grandmother followed with the mother. When asked where the child slept, the grandmother reported with the mother. The father was incarcerated during the investigation and SCDSS met with him face-to-face to interview him and offer services. SCDSS documented efforts to interview the maternal uncle but he refused to be interviewed.

SCDSS spoke to first responders and gathered information regarding the death. Law enforcement attended the medical examiner's doll re-enactment of the death and reported based on the information at that time, they believed the child died from positional asphyxiation. Law enforcement reported no concerns for criminality regarding the child's death and that they did not think the mother was neglectful. Law enforcement stated that although the mother co-slept with the child, the mother practiced preventive measures while co-sleeping, including putting a border of pillows around the child. When law enforcement arrived to the home following the 911 call, the grandmother was pacing around the living room and the mother was bringing the child down the hallway to them. It was unclear if the mother or grandmother attempted CPR. Law enforcement initiated CPR until emergency medical services arrived and transported the child to the hospital.

SCDSS learned from medical records and law enforcement that the child was born prematurely at 36 weeks. The child was brought to the hospital when he was 1 to 2 weeks old due to concerns regarding his prematurity, but nothing there were no concerns at that time. The child was noted to be gaining weight and doing well. There were concerns documented for domestic violence by the father against the mother, which the pediatrician provided support around. SCDSS contacted the hospital regarding what safe sleep guidance was provided to new mothers. Hospital staff reported upon admission, every mother is given a booklet that addressed various child safety issues including safe sleep, and that parents are educated in the delivery room by a nurse.

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: 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
063754 - Deceased Child, Male, 1 Mons	063755 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
063754 - Deceased Child, Male, 1 Mons	063755 - Mother, Female, 21 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 attempted to interview the uncle face-to-face but he refused to participate.

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 parents were offered grief counseling and funeral assistance. The mother enrolled in mental health counseling.

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
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco
☐ Experienced domestic violence
☐ Used illicit drugs
☐ Had a positive toxicology at the time of delivery
☐ Used prescription drugs
☐ Used marijuana
☐ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ With fetal alcohol effects or syndrome
☐ Exhibiting withdrawal symptoms
☒ 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