Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-008

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: 5 month(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 02/13/2023
Initial Date OCFS Notified: 02/13/2023

Presenting Information

An SCR report alleged that on the morning of 2/13/23, the mother found that the 5-month-old female subject child was having difficulty breathing. The mother contacted the child's pediatrician and then drove the child to the hospital. The mother and child arrived at the hospital at 6:41 AM. The child was cold to the touch and unresponsive upon arrival. The child's temperature was 88 degrees which indicated that the child had been dead for some time. There were many inconsistencies in the timeline of events and the mother gave conflicting explanations for the death of the child. Both the mother and father were home and caring for the child at the time of her death.

Executive Summary

This fatality report is regarding the death of a 5-month-old female child that occurred on 2/12/23. A report was made to the SCR on 2/13/23 and alleged DOA/Fatality and Inadequate Guardianship against the mother and father regarding the subject child. The child resided with her mother, father, and two siblings, 12 and 8 years old. The safety of the siblings was assessed regularly throughout the investigation and appropriate safety plans were implemented when necessary.

Suffolk County Department of Social Services (SCDSS) investigated the death by interviewing the family and collateral contacts and gathering pertinent documentation. It was learned the weekend leading up to the death the child began showing symptoms of congestion. The mother treated the child at home and planned to monitor the child until she could bring her to the pediatrician on Monday 2/13/23. On Sunday 2/12/23, the child's symptoms were worsening. The mother felt the child needed medical attention, but did not think the child required emergency medical care and maintained her plan to call the child's pediatrician the following day. The child was placed to sleep at 6:30 PM and woke twice throughout the evening. The mother reported no abnormalities with the child at those times, other than the child not wanting to eat during one of her wake-ups. On 2/13/23 between 5:30 and 6:00 AM, the mother woke up and when she went to retrieve the child from her crib, the mother heard the child wheezing and gulping. The mother quickly got dressed and drove the child to the emergency department where the child was pronounced deceased at 6:52 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 congenital heart abnormality. There was no evidence of trauma to the child. Law enforcement investigated the fatality and based on the preliminary information gathered, were treating the child's death as if it was due to natural causes. Law enforcement noted they had no concerns for criminality regarding the death and no concerns for substance misuse by the parents.

Upon learning of the death, SCDSS implemented a safety plan until additional information could be gathered. The siblings stayed with the paternal grandmother, with no unsupervised contact with the parents. The safety plan was terminated at the completion of the 7-day safety assessment; however, the decision-making regarding the end of the plan was not documented. The siblings returned to the home with the parents and were assessed to be safe in their care. The family was offered bereavement services, which the mother reported she intended to enroll herself and the children in.

SCDSS found there was a fair preponderance of evidence to substantiate the allegations against the mother and father. SCDSS determined through collateral contacts and the parents' interviews that the child was born prematurely and suffered from health issues since birth, in addition to a respiratory illness that affected the child's well-being. The parents acknowledged that the child displayed symptoms of illness over the weekend of 2/10/23; however, knowing of her health issues, neither parent sought immediate medical attention until 2/13/23, after the child's health deteriorated. Hospital staff

reported that due to the child's heart condition, the parents should have obtained immediate medical attention when the child displayed signs of illness. The hospital records revealed the death was noted to be a result of cardiopulmonary arrest possibly secondary to underlying Tetralogy of Fallot (child's heart condition). In addition, the parents reported being aware of safe sleep practices but the child slept with a blanket, which she routinely pulled over her head. Due to the information gathered, the investigation was indicated and closed on 4/14/23.

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?** Yes

Explain:
The safety of the siblings was regularly assessed throughout the investigation. SCDSS supported their determination with the information they gathered throughout the 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:
All 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

Child Fatality Report

Incident Information

Date of Death: 02/13/2023 **Time of Death:** 06:52 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? No
Did EMS respond to the scene? No
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:

- ☒ 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	Female	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)

LDSS Response

Upon receipt of the SCR report on 2/13/23, 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.

The subject child was born prematurely at 29 weeks and was admitted to the intensive care unit. While hospitalized, the child contracted a respiratory virus, which the parents reported caused her ongoing respiratory issues. Hospital staff reported the parents were appropriate with the child's care and participated in all medical training and counseling. The child was released from hospitalization on 10/19/22. The child had a cardiologist who monitored the child's condition, and the child was intended to have heart surgery once she grew in size.

SCDSS interviewed the parents who reported the siblings and father became ill the week before the child's death. The mother attempted to limit contact between the child and the sick family members. On Friday 2/10/23, the child became symptomatic with congestion, a runny nose, and her breathing was faint. The mother called the pediatrician, who told the mother to monitor the child and to come to the office on Monday if the child was not feeling better. On Saturday 2/11/23, the mother reported the child appeared to be okay; however, on Sunday 2/12/23, the child was worse with a runny nose

and fainter breathing. The child ate less than normal and had her last bottle around 12:00 AM before going to sleep. On the day of the death, the mother woke up around 5:00 AM and checked on the child who had slept through the night. The child took two big gulps of air and then began to breathe faintly. The mother picked the child up out of her crib and brought her downstairs and placed her in a swing. The child was breathing abnormally and her heart was pounding. The mother intended to take the child to the pediatrician once the siblings were on the school bus; however, decided to drive her to the hospital once her heart began pounding. The parents reported they did not call 911 because it took them a couple of hours to respond to calls. The mother and child arrived at the hospital a nurse came and took the child and began performing CPR. The father remained at home with the siblings until he was informed by the mother of the child's condition.

SCDSS interviewed hospital staff, who reported the mother arrived to the hospital with the child around 6:20 AM. The child was not breathing, had no pulse, and was cold to the touch. Resuscitation efforts were initiated but were unsuccessful and the child was declared deceased at 6:52 AM. The death was noted to be a result of cardiopulmonary arrest possibly secondary to underlying Tetralogy of Fallot (child's heart condition). The doctor reported the child's body temperature was 88 degrees. While unable to say how long the child was deceased, the doctor provided that body temperature typically dropped 2 degrees per hour post-death. SCDSS inquired with the parents following receipt of that information. The parents were unaware of a normal temperature for a child. The parents maintained that the child was alive at the time the mother brought her to the hospital. The doctor reported that given the child's heart condition, any signs of illness should have been assessed by the pediatrician or emergency department.

SCDSS interviewed the 12yo sibling who disclosed no concerns. The 8yo sibling was nonverbal and unable to be interviewed but was observed. The siblings were up to date on medical appointments and in receipt of necessary services through their school. SCDSS attempted to interview the mother's 17yo child who resided with his father. The father of the 17yo refused contact with SCDSS and reported the 17yo had no contact with the mother. Grief counseling services were offered to the parents and siblings and the mother reported she intended to enroll the family in them.

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 DSS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064040 - Deceased Child, Female, 5 Mons	064042 - Father, Male, 35 Year(s)	DOA / Fatality	Substantiated
064040 - Deceased Child, Female, 5 Mons	064042 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
064040 - Deceased Child, Female, 5 Mons	064041 - Mother, Female, 39 Year(s)	DOA / Fatality	Substantiated
064040 - Deceased Child, Female, 5	064041 - Mother, Female, 39	Inadequate	Substantiated

Mons	Year(s)	Guardianship	

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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? Yes

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

In 2009, the mother and father had an indicated CPS investigation regarding the mother's 17-year-old child and another child. The report was indicated after it was discovered the father sold drugs out of the home and there were weapons accessible to the children. The mother was aware of the drug sales and weapons in the home. The father was arrested. SCDSS filed a neglect petition against the parents and the sibling was placed in the custody of the maternal grandmother.

In 2018, an SCR report alleged IG against the mother and IG and XCP against the father regarding the 17, 12, and 8-year-old siblings and another child. The investigation was indicated against the father after it was discovered the father hit the other child on the head repeatedly with a closed fist, grabbed him by the neck, and slammed him on the ground. The father was charged with endangering the welfare of a child. The biological father of the 17-year-old and other child obtained

custody of his children. The 12 and 8-year-old remained in the mother and father's custody with the agreement that the father would refrain from using physical discipline.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

Between 2009 and 2011, the family had an open services case due to the indicated CPS investigation in 2009. The sibling was placed in the custody of the maternal grandmother through an Article 1017 Direct Placement. The mother regained custody on 7/7/10 after completing a substance use evaluation with no recommendations for treatment. The court orders expired on 4/23/11. The father completed inpatient substance misuse treatment and was successfully engaged in outpatient treatment. The children's safety was assessed and there were no concerns. There was no extension of the court orders requested and the case was closed.

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