Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-020

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

Issue Date: Oct 13, 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: 5 year(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 04/24/2023
Initial Date OCFS Notified: 04/26/2023

Presenting Information

An SCR report received on 04/26/23 alleged that on an unknown date in 2018, the child sustained nonaccidental head trauma that resulted in an anoxic brain injury while in the care of the aunt. As a result of the brain injury, the child was nonverbal, developmentally delayed and unable to walk. Due to the child's physical limitations from the brain injury, on 04/24/23, she became unresponsive while being transported to the hospital. The child went into cardiac arrest on 2 occasions. At 10:12 PM, a do-not-resuscitate order was issued, and the child was pronounced deceased. The child died as a result of the head trauma she sustained when she was 8 months old.

Executive Summary

This report concerns the death of the 5-year-old child that occurred on 04/24/23. A report was made to the SCR on 04/26/23 alleging the child died as a result of injuries she sustained when she was 8 months old. The injuries were unexplained and medical professionals determined they were nonaccidental. The parents and aunt were investigated for the injuries in 2018; however, the adults denied harming the SC. As a result, the child and sibling were placed in Foster Care until they were released to their parents in 2020. At the time of the death, the child resided with her parents and 10-year-old sibling. The aunt had children, aged 5, 10 and 12 years. The children were assessed to be safe in the care of their parents.

Suffolk County Department of Social Services (SCDSS) gathered information regarding the fatal incident during a CPS investigation that began on 08/15/18. That investigation was reviewed, and information regarding the fatal incident was obtained. SCDSS coordinated investigative efforts with law enforcement. At the time of the fatal incident, no criminal charges were filed. Following the death, the criminal investigation remained pending. An autopsy was performed; however, the autopsy report was not yet received at the time of this writing.

In 2018, the parents and aunt were interviewed by SCDSS and law enforcement. The adults denied inflicting injuries to the child. The injuries consisted of retinal hemorrhaging, a buckle fracture to the right leg, and “abusive head trauma.” Following the death, the adults did not provide additional information as to how the child sustained her injuries. The parents stated the child appeared to have a cold in the days leading to her death, and that she saw a pediatrician and was referred to a hospital for an x-ray. While the family was traveling to the hospital, the child became unresponsive. The father carried her into the hospital, where lifesaving measures were unsuccessful. The family had not had contact with the aunt in over 2 years; therefore, the aunt did not have information regarding the death.

SCDSS gathered collateral information from hospital staff, the medical examiner, and the pediatrician. There were no concerns for the parents’ care of the child after being returned to their custody. She appeared well-cared for and there were no incidents or suspicious injuries after the child was discharged from Foster Care.

SCDSS completed required reports and Safety Assessments timely and accurately. Interviews with the family, aunt and collateral contacts were appropriate. The parents and aunt were previously appropriately substantiated for the injuries believed to be inflicted on the child in 2018. Although only the mother was the alleged subject of the death reported to the SCR, SCDSS added the DOA/Fatality allegation against the father and the aunt to the investigation. SCDSS was not authorized to add the allegation as DOA/Fatality and the record did not reflect SCDSS attempted to report the father or aunt’s possible roles in the death to the SCR. No new information regarding the fatal incident was gathered; therefore, the parents and aunt were indicated in the fatality investigation. The Investigation Conclusion Narrative stated the child

suffered from an infection that caused the child to suffer cardiac arrest and ultimately pass away. It remained unclear where this information was obtained. Additionally, the conclusion stated that in the ME's professional opinion, the SC died from a complication that was a direct result of the head trauma she sustained as an infant.

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 case was closed after all required casework activities were met.

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 inappropriately added the allegation of DOA/Fatality against the father and aunt themselves, rather than reporting their concerns to the SCR.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Child Fatality Report

Date of Death: 04/24/2023 **Time of Death:** 10:12 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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Female	33 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	41 Year(s)
Other Household 1	Other Child - Cousin	No Role	Female	10 Year(s)
Other Household 1	Other Child - Cousin	No Role	Female	12 Year(s)
Other Household 1	Other Child - Cousin	No Role	Male	5 Year(s)

LDSS Response

On 08/15/18, SCDSS received an SCR report that concerned the unexplained, nonaccidental physical abuse of the SC. The record regarding that investigation was reviewed and noted that on 08/14/18, the parents sought medical attention for the SC, stating she was not playing or eating normally for 5 days. The pediatrician attributed the SC's behavior to teething. The investigation contained information that the SM brought the SC to the PA's home then she went to work. The PA recalled putting the SC down on the couch and left the room. She turned to look at the SC, and the SC was laying on her side with labored breathing; however, the record also noted the PA found the SC on the floor. The PA called 911 and the SC was transported to the hospital. The SS denied the adults were physically aggressive, rough or "mean" to the SC.

During the investigation regarding the injuries, hospital staff noted the SC had seizure-like activity, brain bleeds, retinal hemorrhages, and a fractured leg. Medical professionals said the injuries were likely to have occurred within 72 hours, and the injuries were too significant to have been caused by another child. Therefore, SCDSS removed the SC and SS on an

emergency basis, and they were placed in foster care. SCDSS filed an Abuse Petition, and a services case was opened. The SC remained hospitalized until 09/05/18, and then she was placed in a foster home. The SC and SS were returned to the parents after they met all court-ordered requirements, and the children were assessed to be safe in their care.

On 04/26/23, SCDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, the ME and DA's offices were made aware of the death, a CPS history check was completed, and both LE and the source were contacted. The safety of the surviving children was assessed.

After the death, hospital staff reported that the parents called the pediatrician on 04/21/23 as she had a fever and cold-like symptoms. The parents were told to bring her to the office on 04/24/23. At the office visit, the parents were advised to bring the SC to the hospital for a chest x-ray. The hospital staff performed lifesaving measures to no avail.

On 04/26/23, a home visit was made, and the family was interviewed. The SF said that on 04/22/23, the SC had a cold, her feeding tube was malfunctioning, and she did not appear to feel well. The SC's chest was congested, and the parents scheduled a pediatrician appointment for 04/24/23. The pediatrician advised the SC to go to the hospital for a chest x-ray. The hospital performed an x-ray and then told the family to return home, but the SC stopped breathing when the SF was putting her into the car. The SF carried the SC back into the hospital, yet lifesaving efforts were unsuccessful. The SM's recollection was consistent with the SF's statement. The SS said he felt safe with his parents.

SCDSS gathered medical records from the pediatrician. It was noted that the SC had 43 active problems as a result of physical abuse; however, there were no current concerns for the care the parents provided to the SC.

SCDSS determined and closed the investigation after gathering enough information to determine the allegations and assess the safety of the surviving children. It was determined the family did not need further intervention from SCDSS.

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
064728 - Deceased Child, Female, 5 Yrs	064858 - Father, Male, 35 Year(s)	DOA / Fatality	Substantiated
064728 - Deceased Child, Female, 5 Yrs	064858 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
064728 - Deceased Child, Female, 5 Yrs	064858 - Father, Male, 35 Year(s)	Internal Injuries	Substantiated
064728 - Deceased Child, Female, 5	064857 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated

Yrs			
064728 - Deceased Child, Female, 5 Yrs	064857 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
064728 - Deceased Child, Female, 5 Yrs	064857 - Mother, Female, 32 Year(s)	Internal Injuries	Substantiated
064728 - Deceased Child, Female, 5 Yrs	064878 - Aunt/Uncle, Female, 33 Year(s)	DOA / Fatality	Substantiated
064728 - Deceased Child, Female, 5 Yrs	064878 - Aunt/Uncle, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
064728 - Deceased Child, Female, 5 Yrs	064878 - Aunt/Uncle, Female, 33 Year(s)	Internal Injuries	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
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 family was offered appropriate services in response to the 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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐
Explain as necessary: The children did not need to be removed as a result of 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	Offered, but	Offered, Unknown	Not Offered	Needed but	N/A	CDR Lead to

	Death	Refused	if Used		Unavailable		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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The surviving sibling was referred to bereavement services. It remained unknown if the service was utilized.

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 bereavement services. It remained unknown if they utilized the service. The family declined burial assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

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

04/09/19- 05/03/19 The aunt and uncle were substantiated for IG regarding their children.

08/15/18- 09/06/18 An SCR report contained concerns that the child fell, became unresponsive and required medical attention while in the care of the aunt. The child had suspicious injuries, including a brain bleed and a fractured leg. The parents and the aunt did not have a plausible explanation for the injuries; therefore, the allegations were indicated against them. The child and then 6-year-old sibling were removed from the parents and placed with another aunt and uncle. Due to her injuries, it was expected that the child would need 24-hour care for the remainder of her life.

08/20/18- 09/20/18 The aunt was substantiated for IG regarding her children.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Preventive Services History

On 08/23/18, a services case was opened for the aunt and her CHN after the SC sustained nonaccidental injuries. A petition was filed on behalf of the SC and the aunt's CHN. The aunt was ordered out of her home and an OP was granted on behalf of her CHN. The aunt was provided with casework counseling, MH counseling, and parent training. There were no concerns for the CHN, and they were deemed safe. The aunt's court order expired, allowing her to return home with her CHN. The services case remained open until 09/21/21.

Foster Care Placement History

The SC and SS were removed on an emergency basis on 08/21/18 and Abuse Petitions were filed in Family Court against the parents 08/24/18. The removal was upheld on 08/27/18. The children were removed due to unexplained nonaccidental physical injuries to the SC. It remained unknown at what time the SC sustained the injuries, or who she was with at the time. The parents and aunt were indicated in the CPS investigation concerning the injuries. Due to the removal, a services case began on 08/23/18. The family was provided with casework counseling, MH counseling, and parent training. The child and sibling remained in foster care while the parents participated in court-ordered services. After the parents met all mandates, the CHN were returned to them on 08/07/20. The case remained open until 08/10/21, when the court orders expired, and the family no longer required services.

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