Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-025

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

Issue Date: Oct 31, 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: 7 month(s)
Jurisdiction: Nassau
Gender: Female
Date of Death: 05/17/2023
Initial Date OCFS Notified: 05/17/2023

Presenting Information

An SCR report was received on May 17, 2023, and alleged the mother put the 7-month-old subject child down for a nap, placing her on her stomach, in her crib. The mother checked on the child and noticed she was not breathing. The mother called 911 at 3:43PM, and was directed how to give cardiopulmonary resuscitation. Emergency medical services arrived at the residence and transported the child to the hospital where she was pronounced deceased. The child was otherwise healthy child, and the mother was unable to provide an explanation for the death.

Executive Summary

This report concerns the death of the 7-month-old female child that occurred on May 17, 2023. Nassau County Department of Social Services (NCDSS) received an SCR report on May 17, 2023, regarding the fatality. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother. At the time of her death, the subject child resided with her mother, maternal great-aunt (MGA), maternal great-uncle (MGU), and 12-year-old second cousin (OC). The biological father resided in Queens, NY and had regular and consistent contact with the child. NCDSS immediately assessed the safety of the cousin, interviewed him, and assessed the residence.

Through a joint investigation with law enforcement, it was learned on May 17, 2023, the mother returned home from work at 6:00AM and observed the child was awake. At 7:30AM, the mother fed the child a 6oz bottle of formula and put the child down for a nap, placing her on her stomach. Around 3:43PM the mother observed the child was still laying on her stomach in the crib and had a comforter over her face. The mother grabbed the child and observed that she was blue and not responsive. The mother contacted 911 while the maternal great-aunt attempted CPR. Emergency medical services arrived and transported the child to the hospital where she was pronounced deceased.

NCDSS communicated with law enforcement and learned their criminal investigation was still open as they were waiting for toxicology results and the final autopsy report. Per law enforcement, the physician that pronounced the child deceased indicated there were no signs of trauma and the death could have been respiratory related. In addition, law enforcement reported thus far, the death appears to be a “tragic accident.” At the time this report was written, there were no criminal charges pending against the mother. NCDSS contacted the medical examiner; however, were unable to obtain information as the autopsy had not yet been finalized.

The allegations of DOA/Fatality and Inadequate Guardianship against the mother were substantiated. NCDSS found there was a fair preponderance of evidence to support the above allegations and the case was closed on July 7, 2023. The record reflected NCDSS completed their investigation, required reports and safety assessments timely and accurately. The risk assessment was reflective of case circumstance and several visits were completed with the family.

NCDSS provided the mother with bereavement referrals and offered burial assistance; however, she declined burial assistance. Administration for Child's Services (ACS) spoke to the father and provided him information regarding bereavement services. NCDSS spoke with several collaterals including the child’s pediatrician, the mother’s boyfriend, the paternal aunt, and several other family members. All collaterals denied concerns for the mother as well as her ability to care for the child. NCDSS discussed safe sleep practices with the mother and father regarding any future children.

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:
NCDSS made an appropriate determination based on evidence 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:
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

Incident Information

Date of Death: 05/17/2023 **Time of Death:** 04:36 PM

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

County where fatality incident occurred: Nassau

Was 911 or local emergency number called? Yes

Time of Call: 03:43 PM
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:

- [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	Female	41 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	50 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Other Child - second cousin	No Role	Male	12 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)

LDSS Response

On May 17, 2023, NCDSS received a report regarding the death of the SC. NCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. NCDSS contacted the source of the report, reviewed prior CPS history and promptly notified the Medical Examiner and District Attorney. NCDSS interviewed the subject mother as well as other household members and assessed the safety of the OC that lived in the residence.

NCDSS interviewed the SM who reported she returned home from work around 6:00AM, and retrieved the child from upstairs, where she slept while the mother was working. The mother observed the child to be alive and well and brought her downstairs to the basement where they resided. At 7:30AM, the mother fed the child a 6oz bottle of formula and laid her down for a nap, placing her on her stomach in her crib. In addition, the mother noted there was a long pillow in the crib that she used to prevent the child from banging her head on the railings. The mother then put a full-sized comforter over the crib, leaving it half open to block the light that came in through the window. During her interview, the mother reported the child's normal sleep position was on her stomach and she slept better with less light. The mother then went to take a nap, when she woke, she was unsure what time it was and went to check on the child. The mother observed the child on her stomach and the comforter over her face, she picked up the child and noticed she was blue and not breathing. The mother then ran upstairs for help and EMS arrived shortly after. The mother denied hearing the child cry.

NCDSS interviewed the MGA who reported caring for the child Monday-Friday while the mother was at work. She explained the mother and child resided in the basement of her residence, but, when the mother was at work, the child would sleep upstairs in a "Pack 'n Play" located in a spare bedroom. Regarding the incident, the MGA reported around 3:45PM she heard a loud noise and thought it was her dogs. She then reported the mother came running up the stairs with the child in her hands saying that the child was not breathing. The MGA took the child and instructed the mother to contact

911 but the mother was unable to communicate what was happening, so the MGA spoke to 911. The MGA performed CPR on the child and when doing so, the child had formula coming out of her mouth. In response to the formula, the MGA was also tapping the child on her back to get the formula out. EMS arrived quickly and transported the child to the hospital. During her interview, the MGA denied having concerns for the mother and her parenting abilities.

NCDSS interviewed the 12-year-old OC who reported hearing a loud noise and thought it was the families' dogs. He then saw the mother run upstairs with the child in her arms, the child's color was blue, and he indicated she was not breathing. He confirmed that formula was coming out of the child's mouth when she was given CPR and observed the ambulance arrive and take the child. He denied any concerns for the mother and stated she was good with the child.

ACS interviewed the father who explained he had last seen the child two days prior to the fatality and indicated she was suffering from a common cold but appeared fine. Regarding the incident, he reported the mother told him she overslept and when she woke up the baby was blue. He denied any concerns for the mother and her parenting abilities. During his interview, the father confirmed the child slept in her crib and she would always be placed on her stomach.

Collateral contact with the SC's pediatrician revealed she was seen regularly for well child visits; her immunizations were slightly delayed due to an appointment that needed to be rescheduled. The pediatrician had no concerns for the SC and noted she always appeared well-kept. Contact with the OC's pediatrician revealed there were no concerns for his physical health.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
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? Yes
Comments: Nassau County referred this case to their OCFS approved Child Fatality Reiew Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063819 - Deceased Child, Female, 7 Mons	063820 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
063819 - Deceased Child, Female, 7 Mons	063820 - Mother, Female, 21 Year(s)	Inadequate Guardianship	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?	☐	☐	☒	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
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	☐	☐	☐	☐	☐	☒	☐

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? Unable to Determine
Explain:
The record does not reflect NCDSS provided the OC or his parents with information regarding counseling services; however, the OC was enrolled and participating in counseling services after the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
NCDSS along with ACS provided the mother and father with information regarding bereavement services.

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
- ☐ 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/01/2020	Aunt/Uncle, Male, 13 Years	Grandparent, Female, 42 Years	Other	Unsubstantiated	No
	Aunt/Uncle, Female, 13 Years	Grandparent, Female, 42 Years	Other	Unsubstantiated	
	Aunt/Uncle, Male, 13 Years	Mother, Female, 19 Years	Other	Unsubstantiated	
	Aunt/Uncle, Female, 13 Years	Mother, Female, 19 Years	Other	Unsubstantiated	
	Aunt/Uncle, Male, 13 Years	Grandparent, Male, 41 Years	Other	Unsubstantiated	
	Aunt/Uncle, Female, 13 Years	Grandparent, Male, 41 Years	Other	Unsubstantiated	

Report Summary:
Nassau County Family Court ordered a 1034 court ordered investigation that was returnable on 10/22/20. Regarding the concerns, there was an incident where the MGM was on a motorcycle and the twin maternal aunt and uncle were in the car with the MGF when he accelerated.

Report Determination: Unfounded **Date of Determination:** 10/23/2020

Basis for Determination:
The MGF filed for a modification of visitation regarding the maternal aunt and uncle. The SM was listed on this case as a subject. The children reported feeling safe with both parents and did not identify any concerns for the SM, MGM or MGF. Both residences were observed, and no safety concerns were noted. The case was unfounded and closed.

OCFS Review Results:
The record reflected NCDSS initiated their investigation within 24 hours, contacted the source and reviewed CPS history. The Seven-Day Safety Assessment, Risk Assessment Profile and investigation determination were all completed timely and accurately. Home assessments and interviews were completed will all individuals listed on the case.

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

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 is 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