Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-029

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

Issue Date: Dec 08, 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: 8 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 06/21/2023
Initial Date OCFS Notified: 06/21/2023

Presenting Information

Two SCR reports alleged that on 6/21/2023, the mother placed the 8-month-old male subject child down to sleep in the bed with herself and the 8 and 6-year-old siblings. The mother awoke at about 4:20AM and discovered the child, lying in the bed between her and one of the siblings, was not breathing and was cold to the touch. The mother called 911 while the grandmother and the maternal aunt attempted to perform cardiopulmonary resuscitation on the child. EMS arrived at about 5:01AM and attempted to intubate the child but were unsuccessful. EMS transported the child to the hospital and the child was pronounced deceased at 5:30AM. The child was an otherwise healthy child, and it was thought the unsafe sleep situation contributed to the child's death. The mother had no explanation for his death.

Executive Summary

On 6/21/23, Suffolk County Department of Social Services (SCDSS) received two SCR reports regarding the death of the 8-month-old male subject child. The report alleged DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child. At the time of the death the child resided with the mother, 8 and 6-year-old siblings, maternal grandmother, maternal aunt, 11 and 9-year-old maternal aunts, and 17-year-old cousin. The child's father was incarcerated prior to his death. The maternal grandfather lived in a separate home and visited with the children.

On the night prior to the death, the mother fed the child a bottle between 11:00PM-11:30PM. After the child finished his bottle, the mother placed the child to sleep on the mother's bed on his back next to the 3-year-old sibling that was already asleep in the bed. The mother placed a pillow under the child's head and a blanket over him, and he fell asleep around 12:00AM. The mother woke up around 4:30AM. The child was observed on his side, unresponsive, and cold to the touch. The mother picked the child up and yelled for the maternal grandmother. The maternal grandmother called 911, while the mother and maternal aunt began CPR until first responders arrived. First responders arrived, took over resuscitative measures, and transported the child to the hospital. The child had no vitals upon arrival at the hospital, and hospital staff administered life-saving measures; however, were unsuccessful and the child was pronounced deceased at 5:30AM.

An autopsy was performed; however, the final autopsy was pending at the time this report was written. SCDSS contacted the medical examiner and the record reflected there were no signs of trauma found on the child's body and that the death could have been related to unsafe sleep practices. Law enforcement investigated the death and found no criminality regarding the death; however, at the time the CPS investigation closed it was unclear what the status of the criminal investigation was.

SCDSS interviewed the siblings and the minor age maternal aunts, and they were assessed as safe with the mother and maternal grandmother. The children were asleep at the time of the fatal incident and had no information regarding the child's death. The children said they were told to go into the bedroom and close the door. The father of the child was interviewed by phone and had no concerns for the mother or the siblings. SCDSS offered the father bereavement services, and he declined. The record did not reflect the maternal grandfather was offered any services. SCDSS offered the family grief counseling and burial assistance, and the family accepted. The children were engaged with grief counseling services prior to the case closure.

SCDSS found there was a fair preponderance of the evidence to substantiate the allegations of the SCR report against the mother. SCDSS determined that despite the mother being aware of the dangers of co-sleeping with the child, the mother confirmed that she routinely co-slept with the child and the 3-year-old sibling. The mother's actions and unsafe sleep

practice placed the child at immediate risk of harm and likely contributed to the child's death. The case was indicated and closed on 8/18/23.

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:
SCDSS made an appropriate determination based on the evidence obtained 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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the 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: 06/21/2023 **Time of Death:** 05:30 AM

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Unknown
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	Aunt/Uncle	No Role	Female	19 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	11 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	9 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	8 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	17 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)
Other Household 2	Grandparent	No Role	Male	47 Year(s)

LDSS Response

Within the first 24 hours of the investigation, SCDSS contacted the sources of both reports, notified law enforcement, the medical examiner, and the district attorney's office of the death. Throughout the investigation SCDSS completed interviews with the family and gathered information from medical collaterals and school staff.

SCDSS completed a home visit to the mother's home and interviewed the SM, MA, MGM, SSs, and minor MAs. The father was incarcerated prior to the SC's death and was interviewed over the phone. There were no concerns for the condition of the home. SCDSS learned the family had been at a relative's home all day for a picnic and arrived home around 10:00PM. The older siblings went to bed and the SM brought the 3yo SS and the SC to her bedroom. The 3yo SS went to sleep in the SM's bed and the SM gave the SC a bottle between 11:00PM-11:30PM. After the SC finished his bottle, the SM placed him on the bed on his back. The SM had pillows on her bed and placed a blanket over the SC and he

fell asleep around 12:00AM. The SM said she laid down and fell asleep about 20 minutes later. At about 4:30AM, the SM woke up and the SC was unresponsive in the bed on his side, and he was cold to the touch. The SM was unsure if the 6yo SS was in the bed, she said he sometimes would come in at night and lay across the bottom of the bed. The 3yo SS was in the bed but not close to the SC. The SM picked up the SC and screamed for the MGM and MA. The MGM called 911, while the SM and adult MA attempted to resuscitate the SC until first responders arrived. The SM reported the 3yo SS regularly slept in her bed and the SC had been sleeping in the SM's bed for about a month, because the SC grew out of the bassinet. The SM reported she did this with all her children. The SSs and the minor MAs were asleep and were woken up by the SM yelling "my baby". The children were told to go into a bedroom and close the door while the MGM called 911. The BF disclosed the SC was sleeping in the bassinet when he was in the home; however, if the SC woke up, the SM would place the SC in the bed until he fell asleep and then the SM would place the SC back in the bassinet. The BF had no concerns for the SM or her care of the SSs.

SCDSS gathered information from numerous collateral contacts including the children's pediatrician, schools, hospital staff, and law enforcement. SCDSS reviewed medical records from the pediatrician and there were no concerns for the SSs or the minor age MAs. The record did not reflect SCDSS offered the MGF services. At the close of the investigation, the children were deemed safe with the SM and MGM. SCDSS found evidence to support the allegations in the report and appropriately substantiated and closed the investigation.

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
064193 - Deceased Child, Male, 8 Mons	065433 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
064193 - Deceased Child, Male, 8 Mons	065433 - Mother, Female, 29 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?	☐	☐	☒	☐

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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary:							

The children engaged with bereavement services after the death; however, at the close of the investigation it was unknown if the SM and MGM engaged with bereavement services. The father of the siblings declined services and the record did not reflect the MGF was offered services.

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 SM and MGM accepted bereavement services on behalf of the children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS offered the SM and MGM bereavement services and burial assistance, and they accepted.

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

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

The mother had custody of the 17-year-old cousin at the time of the subject child's death. The cousin had prior CPS history with her parents with common allegations of IG, PD/AM, and LMC.

In 2016, the 11yo and 9yo MAs were listed on an indicated report with allegations of IG against the MGF.

In 2013, the 11yo MA was listed on an unfound report with allegations of IG against the MGM and MGF.

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