



## Report Identification Number: SV-23-043

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

**Issue Date: Jan 17, 2024**

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

<b>Relationships</b>		
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	
<b>Contacts</b>		
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	
<b>Allegations</b>		
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
<b>Miscellaneous</b>		
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:** 1 year(s)

**Jurisdiction:** Suffolk  
**Gender:** Female

**Date of Death:** 07/31/2023  
**Initial Date OCFS Notified:** 07/31/2023

## Presenting Information

Suffolk County Department of Social Services (SCDSS) received an SCR report on 7/31/2023, which alleged the maternal grandmother (MGM) drove the mother (BM) to work and then was supposed to drive the 1-year-old child (SC) to daycare. The maternal grandmother forgot to bring the child to daycare and drove 20 minutes to her job. The maternal grandmother went inside, worked from 8:00 AM until 4:00 PM and returned to her car. The maternal grandmother drove to the child’s daycare, went inside to pick her up, and was informed by daycare staff the child was not in attendance that day. The grandmother left the daycare, began to drive home, looked in the back seat, and saw the child in her car seat. The grandmother pulled over, immediately called 911, and initiated CPR. EMS responded to the vehicle and transported the child to the hospital where she was pronounced dead. The roles of the mother and father (BF) were unknown.

## Executive Summary

Within the first 24 hours of the investigation, SCDSS contacted the source of the report, notified the ME and DA’s offices of the death, documented a CPS history check, interviewed medical collaterals, and interviewed the mother and maternal grandmother.

The grandmother was interviewed in her home and confirmed the narrative of the SCR report. The grandmother stated she received a phone call from work while driving the child to daycare, became distracted, and forgot the child was in the car with her. The grandmother stated that upon seeing the child in her car seat, she immediately pulled over, called 911, and performed CPR as instructed. A passerby stopped to assist until EMS arrived and took over life-saving attempts. The mother was interviewed in her home and confirmed the narrative of the SCR report to her knowledge. The mother did not believe the grandmother intentionally harmed the child and forgot she was in the back seat. The father was incarcerated on charges unrelated to the fatality. The father was interviewed in jail and stated he did not believe the grandmother intentionally harmed the child and believed it was an accident.

SCDSS interviewed law enforcement detectives assigned to the investigation. Law enforcement stated they did not believe there was any criminality by the grandmother and did not expect to press criminal charges against her.

SCDSS interviewed the medical examiner. The medical examiner stated the preliminary cause of death could be attributed to the child being left in the hot car with temperatures reaching as high as 116 degrees inside the car. Additional toxicology tests were pending, and the final autopsy report was pending at the time the investigation was closed.

Services were offered to all parties and declined. The mother, father, and grandmother identified utilizing outside counselors to support them following the death of the child. There were no surviving siblings. The allegations against the grandmother were substantiated and the investigation was closed.

## Findings Related to the CPS Investigation of the Fatality

### Safety Assessment:



- Was sufficient information gathered to make the decision recorded on the:

- Safety assessment due at the time of determination? N/A

**Determination:**

- Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation? Yes, sufficient information was gathered to determine all allegations.
- Was the determination made by the district to unfound or indicate appropriate? Yes

**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.

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: 07/31/2023

Time of Death: 04:45 PM

Time of fatal incident, if different than time of death: 04:00 PM

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? No

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	1 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	53 Year(s)
Other Household 2	Father	No Role	Male	38 Year(s)

**LDSS Response**

SCDSS received the SCR report and initiated their investigation. SCDSS coordinated their response with LE and conducted interviews of the BM, BF, and MGM.

The MGM confirmed the narrative of the SCR report and stated she received a phone call from work while driving the SC to daycare. The MGM stated she forgot the SC was in the back seat and went into her office for the workday. The MGM returned to the car at 4:00 PM, drove to the SC's daycare, went inside, and was informed the SC was not in attendance. The MGM left to drive home, looked in the back seat while driving and located the SC in her car seat. The MGM pulled over, called 911, and began to perform CPR as instructed. A passerby stopped to assist until EMS arrived and took over. The child was transported to the hospital where she was pronounced dead.

The BM was interviewed in her home and stated she believed the MGM did not leave the SC in her car intentionally. The BM stated she received a hysterical phone call from the MGM telling her to go to the hospital and had no knowledge of the incident other than what had been reported. The BF was interviewed in jail and stated he did not believe the MGM intentionally harmed the SC. The BF had no direct knowledge of the incident.

SCDSS interviewed LE assigned to the investigation. LE believed the fatal incident was a tragic accident and did not expect to press criminal charges against the MGM.

The ME was interviewed and preliminarily attributed the SC's death to being left in the hot car on a day in which the temperature inside the car could have reached 116 degrees. The final autopsy report was pending at the time this report was written.

SCDSS interviewed the SC's daycare staff. The daycare staff expressed no historical concerns for the SC in the care of the BM or MGM. SCDSS obtained the SC's medical records from her pediatrician. There were no concerns for abuse or maltreatment identified and the SC had no diagnosed medical conditions.

The allegations of DOA/Fatality, LS, and IG against the MGM regarding the SC were substantiated, and the investigation was closed. Services were offered in relation to the death of the SC and were declined.

**Official Manner and Cause of Death**

**Official Manner:** Pending



**Primary Cause of Death:** Pending

**Person Declaring Official Manner and Cause of Death:** Medical Examiner

### Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?** Yes

**Was the fatality referred to an OCFS approved Child Fatality Review Team?** No

**Comments:** Suffolk County does not have an OCFS approved Child Fatality Review Team.

### SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065612 - Deceased Child, Female, 1 Year(s)	065614 - Grandparent, Female, 53 Year(s)	DOA / Fatality	Substantiated
065612 - Deceased Child, Female, 1 Year(s)	065614 - Grandparent, Female, 53 Year(s)	Inadequate Guardianship	Substantiated
065612 - Deceased Child, Female, 1 Year(s)	065614 - Grandparent, Female, 53 Year(s)	Lack of Supervision	Substantiated

### CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine



Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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### 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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No

**Explain:**  
Services were offered in relation to the death of the SC. The BM, MGM, and BF each identified utilizing outside counseling 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

### CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

### CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

### Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

### Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

### Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes?  Yes  No

Are there any recommended prevention activities resulting from the review?  Yes  No