Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-050

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 has an open 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		
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	
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: 3 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 10/12/2019
Initial Date OCFS Notified: 10/12/2019

Presenting Information

An SCR report received on 10/12/19, alleged that on 10/11/19, while in the care of the mother and father, the 4-month-old child sustained a suspicious internal injury, bleeding from the nose. The child was resuscitated and transported to the hospital, then airlifted to another hospital. On 10/12/19, the child passed away.

Executive Summary

This report concerns the death of the 4-month-old child. Suffolk County Department of Social Services (SCDSS) received an initial report from the SCR on 10/11/19, the day the child became unresponsive after rolling over in his bassinet. On 10/12/19, the child was taken off life support and pronounced dead. SCDSS received a subsequent report from the SCR on the same day regarding the child's death.

The incident occurred in the parent's home, where they resided with the subject child and an unrelated home member. SCDSS confirmed there were no other children living in the home, and the parents had no other children. It was learned the father was home with the infant while the mother was out running errands. The father placed the infant to sleep, on his back in his bassinet. The father then took a nap in his own bed, located in the same room as the bassinet. While out of the home, the mother checked the surveillance cameras located in the home and noted the infant had rolled over onto his stomach. She called the unrelated home member who woke the father and found the infant unresponsive. The father contacted 911 and attempted resuscitation efforts at the direction of the operator while awaiting the arrival of first responders. First responders arrived and transported the child to the hospital where he received emergency treatment until succumbing to his injuries the following morning when he was pronounced deceased at 6:03AM.

SCDSS completed a joint investigation with the Suffolk Police Department and no criminal charges were filed. An autopsy was completed, but the final report had not been received at the time of this writing. Preliminary findings showed no evidence of internal injuries to the child, nor were there any physical indicators the infant had been abused or maltreated. Both the medical examiner and the hospital physician attributed the child's cardiac arrest and bloody nose to suffocating while in the face down position in his bassinet.

SCDSS contacted all necessary collaterals and determined there was no credible evidence to substantiate the allegations of inadequate guardianship, internal injuries, and DOA/fatality against the mother and father regarding the subject child. SCDSS found that all documentation and collateral contacts confirmed the infant to be healthy and his death to be accidental. Neither parent placed the child in an unsafe sleep environment. The infant was appropriately placed to sleep on his back, in his bassinet. SCDSS viewed the recording from the family's home surveillance system and observed the child rolling over onto his belly prior to becoming unresponsive. SCDSS offered grief counseling to the mother, and father. A mental health referral was also made, though it did not appear any services were utilized while the case was open. Once all casework activities were completed adequately, the case 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:
The decision to unfound and close the case was appropriate. There were no surviving siblings or other children in the home thus there was no safety to be assessed.

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 best casework practice.

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: 10/12/2019 **Time of Death:** 06:03 AM

Date of fatal incident, if different than date of death: 10/11/2019
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 alcohol or drugs? No
Child's activity at time of incident:

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

☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 30 Minutes
At time of incident supervisor was:

☐ Drug Impaired
☐ Alcohol Impaired
☐ Distracted
☐ Impaired by disability
☐ Absent
☒ Asleep
☐ Impaired by illness
☐ 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	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

SCDSS initiated their investigation promptly by coordinating with LE and sharing information. In addition to LE, SCDSS contacted the source, hospital, district attorney, the parents, and all related medical personnel. SCDSS reviewed CPS history which revealed that neither the parents nor child were known to the system as confirmed subjects or recipients of services as adults. These actions were completed on the date of the initial SCR report, and further contact with the family and collaterals continued throughout the length of the investigation.

Through interviews conducted with family members and first responders, it was learned the day leading up to the death was a typical day. The mother went to run errands while the father stayed home with the infant. The mother reported checking in on the surveillance system and seeing the infant had rolled onto her stomach. She called the unrelated home member as the father was taking a nap. The unrelated home member woke the father. The father reports he found the infant unresponsive and bleeding from his nose. He immediately called 911 and attempted CPR while awaiting the arrival of first responders. The father was not under the influence of any substances at the time he was caring for the child. The unrelated home member corroborated this information but reports not remembering much else.

SCDSS spoke with the hospital physician who pronounced the child deceased, and received hospital records. Records reflect the child presented to the ER in cardiac arrest on 10/11/19 and attempts to keep the child alive were unsuccessful. The child was intubated, and chest x-rays were completed. The doctor reported the child had no evidence of internal or external injuries and appeared healthy. Palliative care continued until 10/12/19 when the child succumbed to his injuries.

During the investigation, SCDSS gathered information from Suffolk Police Department regarding the video footage of the incident. SCDSS was able to observe the video in its entirety and saw the mother readying herself to go out; the father was seen placing the infant in his bassinet and then getting into his own bed. The video shows the infant roll over on his own to a face-down position. SCDSS observed the infant appear to struggle (his limbs moving about but body remaining still), eventually his movement slowed and then stopped altogether. SCDSS observed the infant to be blue in color. After an

undocumented period, the unrelated home member comes into the camera view and wakes the father who checked on the child. The father is seen picking up the infant who appears limp with blood coming from his nose. Though the video has no sound, SCDSS observed the father panicking and calling what SCDSS assumed to be 911 for assistance. The father was observed in the video attempting CPR.

SCDSS accurately determined the allegations after conducting a thorough investigation. The parents were offered a multitude of services, which they were receptive to. It was unknown if they were utilizing services at the time of this writing.

Official Manner and Cause of Death

Official Manner: Pending
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 reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in Suffolk County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052970 - Deceased Child, Male, 3 Mons	052972 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
052970 - Deceased Child, Male, 3 Mons	052972 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Unsubstantiated
052970 - Deceased Child, Male, 3 Mons	052972 - Mother, Female, 19 Year(s)	Internal Injuries	Unsubstantiated
052970 - Deceased Child, Male, 3 Mons	052971 - Father, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
052970 - Deceased Child, Male, 3 Mons	052971 - Father, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
052970 - Deceased Child, Male, 3 Mons	052971 - Father, Male, 27 Year(s)	Internal Injuries	Unsubstantiated

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?	☐	☒	☐	☐

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:
SCDSS provided the parents with a multitude of resources with regard to grief and mental health counseling. The parents were receptive to the referrals, but it was unknown if they were utilizing services at the time of this writing. Additionally, SCDSS provided the father with substance abuse counseling referrals due to his history of substance abuse.

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? N/A
Explain:
There were no surviving siblings or other children residing in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS offered a multitude of services to the parents following the death.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? 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
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

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 history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

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