Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-050

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

Issue Date: May 24, 2022

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 12/04/2021
Initial Date OCFS Notified: 12/04/2021

Presenting Information

An SCR report alleged on 12/4/21, at approximately 5:00 AM, the 1-month-old male child was found unresponsive in the home while in the care of the parents. The child obtained injuries from a fall and died as a result. There was no explanation provided by the parents regarding the child's fall. The parents were named as alleged subjects of the SCR report, as they were caretakers at the time the child passed away. The role of the 7-year-old sibling remained unknown.

Executive Summary

This fatality report concerns the death of the 1-month-old male subject child that occurred on 12/4/21. A report was made to the SCR on the same day with allegations the child passed away from injuries from a fall while in the care of his parents. At the time of the child's death, he resided with the parents, and the 7-year-old sibling who was assessed to be safe during the investigation. The sibling was the mother's daughter. The whereabouts of the sibling's father remained unknown.

Suffolk County Department of Social Services (SCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final autopsy was pending at the time this report was written. The medical examiner believed the excessive bedding in the child's sleeping environment was a contributing factor in the death. The medical examiner noted there was no suspicious bruising or markings on the child's body. The criminal investigation remained open pending the final autopsy report.

The parents reported the child was placed to sleep on his back in a portable crib with a rolled-up blanket placed around him and under his neck. The father woke up around 5:00 AM and checked on the child, who was unresponsive, not breathing and had blood coming from his nose. The parents became frantic and were screaming and crying which woke the neighbors. A neighbor went to the family's home and saw the child unresponsive. A neighbor called 911 and the father performed CPR until EMS arrived and transported both the father and child to the hospital where the child was pronounced deceased. The parents denied the child fell at any time.

SCDSS gathered information from collateral contacts including first responders, family members, the pediatrician, and several neighbors. There were no concerns for the care the parents provided to the children, and the parents were described to be wonderful parents.

SCDSS conducted home visits and documented thorough interviews. The Safety Assessments and required reports were completed timely and accurately. The Risk Assessment Profile did not accurately reflect case circumstances. The allegations of Inadequate Guardianship and DOA/Fatality were substantiated against both parents, as the investigation revealed there was credible evidence of "culpable carelessness on part of the parents for using excessive bedding." Additionally, the medical examiner believed the parents' actions of putting the blanket in the child's sleeping environment was a contributing factor in the child's death.

SCDSS offered services to the family including bereavement services, funeral assistance, and mental health counseling. The family declined the services stating they had a strong support system. After all casework requirements were met, SCDSS closed their investigation on 2/1/22.

PIP Requirement

SCDSS will submit a PIP to the Westchester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS will review the plan and revise as needed to address ongoing concerns.

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

Explain:
There are no safety issues to be referred back to the local district.

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 close the case was appropriate.

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:
The Risk Assessment Profile was completed inaccurately.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The Risk Assessment Profile was completed inaccurately as it reflected the child did not die as a result of abuse or maltreatment; however, the allegation of DOA/Fatality was substantiated against the parents.

Legal Reference:	18 NYCRR 432.2(d)
Action:	SCDSS will submit a PIP to the Westchester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS will review the plan and revise as needed to address ongoing concerns.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/04/2021 **Time of Death:** 06:01 AM

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: 05:09 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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? 5 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)

LDSS Response

On 12/4/21, SCDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, SCDSS coordinated investigative efforts with law enforcement, notified the medical examiner and district attorney's offices of the death and assessed the safety of the surviving sibling.

Law enforcement provided information that the father reported the child fell asleep around 10:00 PM while being fed a bottle. The father put the child on his back in the portable crib with a rolled-up blanket behind the child's head. The father woke around 5:00 AM and was surprised the child had slept through the night. The father checked on the child and found him unresponsive and not breathing. The neighbors called 911 and the child and father were transported to the hospital via ambulance.

On 12/4/21, SCDSS went to the home and interviewed the mother. The mother said she followed safe sleeping recommendations that she learned at the hospital after the child's birth. She stated the father recently started placing a rolled-up blanket around the child to keep him from rolling over and said it helped if the child spit up during the night. It remained unknown how long the father had been using the blanket prior to the child's death. The father fed the child around 10:00 PM, and around 12:00 AM, the mother fed the child. She placed the child back into the portable crib. Initially, the mother said there was a blanket in the portable crib, but later said neither she nor the father put a blanket in the crib that night. Around 5:00 AM, the father woke up and found the child unresponsive and not breathing with blood on his nose. The parents became frantic, and a neighbor called 911 as requested by the mother. The father gave the child mouth-to-mouth resuscitation until EMS arrived. The child passed away at the hospital.

The sibling was interviewed privately and said she saw the mother feeding the child before bed and the child never slept in bed with the parents. She was present when the parents found the child unresponsive and expressed sadness regarding the death. She said the parents were crying and the child had blood coming from his nose. The sibling heard the parents say the child was not breathing and that he was dead. The sibling reported feeling safe in the care of her parents.

The father was interviewed on 12/7/21 with the mother present. The father's recollection reflected what the mother had reported, and that the child acted normally throughout the day. The parents were not given the medical advice to place the blanket under the child's head; however, it was what they thought was the right thing to do.

SCDSS gathered information from collateral contacts including first responders, family members and neighbors. An EMT reported there were obvious signs of death including rigor mortis when EMS arrived at the home. The neighbors said they woke around 5:00 AM because they heard screaming and crying from the family's home. The mother called one of the neighbors and said the child was not breathing and to call 911. It remained unknown why the mother did not call 911 herself. The other neighbor went into the family's home and the family was hysterical and crying. The child appeared pale and had a bloody nose. The neighbor reported praying with the family until EMS arrived. The neighbors did not have concerns for the children and said the parents took good care of the children. The paternal grandmother did not have concerns for the care of the children and described the parents as amazing.

After completing all required casework, the family did not require further intervention from SCDSS and the case was determined and closed on 2/1/22.

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
060201 - Deceased Child, Male, 1 Mons	060202 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
060201 - Deceased Child, Male, 1 Mons	060202 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
060201 - Deceased Child, Male, 1 Mons	060203 - Father, Male, 38 Year(s)	DOA / Fatality	Substantiated
060201 - Deceased Child, Male, 1 Mons	060203 - Father, Male, 38 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?	☒	☐	☐	☐
Explain: There are no safety issues 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 declined further intervention from SCDSS.				

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
The sibling 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 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 parents declined referrals for bereavement services and mental health counseling. The family had a strong support system through their friends, family and church. The family declined funeral assistance, as the church provided it.

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? No
Explain:
Although bereavement services were offered to the parents regarding the sibling, the family declined the services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? No
Explain:
The parents were offered funeral assistance and bereavement services in response to the death; however, they declined the referrals.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/28/2020	Sibling, Female, 6 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 6 Years	Mother, Female, 25 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged the mother was the sole caretaker of the 6-year-old sibling. The mother was demeaning and called the sibling derogatory names. The mother left the sibling unsupervised overnight in the home and did not make a plan for the sibling. The mother did not pick the sibling up from school at the end of the day and did not make a plan for the sibling. It was unknown if the sibling sustained any physical injuries.

Report Determination: Unfounded | **Date of Determination:** 03/16/2020

Basis for Determination:
The allegations of Inadequate Guardianship and Lack of Supervision were unsubstantiated against the mother regarding the sibling. The mother and sibling denied the allegations and stated that the sibling was transported to and from school on a school bus and the mother was always present for pick up and drop off times. The sibling was not left unsupervised and always had adult supervision. The mother verbally reprimanded the sibling as a form of discipline but did not use derogatory terms.

OCFS Review Results:
The investigation was initiated timely, and a CPS history check was documented. The mother was provided with written notice of the SCR report. The 7-day Safety Assessment was completed untimely. The record did not reflect information was gathered from collateral contacts.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
Although an attempt was made to contact the source of the report and releases of information were sent to the school and pediatrician's office, the record did not reflect follow-up with these contacts was attempted to obtain information.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
SCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
Although a 7-day Safety Assessment was completed, it was completed untimely on 3/11/20.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
SCDSS will document and approve all Safety Assessments within the required timeframes.

[redacted]

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 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