Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-22-011

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

Issue Date: Aug 16, 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 year(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 04/22/2022
Initial Date OCFS Notified: 04/22/2022

Presenting Information

Suffolk County Department of Social Services (SCDSS) received a report on April 22, 2022, alleging that on April 21, 2022, the father and aunt were both present and caring for the subject child and two siblings (ages 7 and 1). At 8:00PM, the aunt gave the subject child a bottle and put her to bed on a lower bunk bed, secured with a guardrail. At 12:00AM the morning of April 22, 2022, the aunt gave the subject child another bottle and did not check on her until 10:00AM. At this time, the aunt found the subject child laying on the lower bunk bed with a pillow and more than one blanket with her. The aunt called 911 because the subject child was black and blue. First responders arrived at 10:07AM and when emergency medical services arrived at 10:08AM, the subject child was purple in color, cold, stiff, and she had vomited on herself. The subject child was pronounced deceased at 10:10AM. The cause of the subject child's death was unknown at the time the SCR report was made.

Executive Summary

This report concerns the death of a 22-month-old female child. Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the child's death on 4/22/22. At the time of the child's death, she resided at home with her mother, father, an unrelated adult (not an aunt as was alleged), and her two surviving siblings. The unrelated adult acted as a live-in babysitter for the family.

On the evening of 4/21/22, the subject child and twin surviving sibling were put to bed around 8:00PM and woke for a bottle around 12:00AM, which is their normal pattern. At the 12:00AM feeding, nothing was observed to be out of the ordinary with the child by the babysitter. The next morning (4/22/22), the surviving twin woke around 9:30AM, which is their typical wake time. When the subject child was checked on around 10:00AM, she was observed to be blue in color. The babysitter called 911 at 10:02AM and attempted CPR. The police department was first to respond at 10:07AM and emergency medical services arrived at 10:08AM. Vomit was observed on the sheets and around the child's mouth, which was noted to be consistent with a seizure. The child was pronounced deceased in the home at 10:10AM.

The medical examiner was notified and performed an autopsy. The preliminary autopsy revealed a well-developed and nourished child with a cause of death likely to be a seizure related death or related to a prone sleeping position in a crowded crib. No fractures or internal injuries to the child were found. Law enforcement was notified of the child's death prior to the report being made to the SCR and began an investigation. Nothing suspicious was observed at the scene. At the time of writing this report, law enforcement had not made any arrests and their investigation remained open. While preliminary autopsy toxicology reports were negative, SCDSS was notified by law enforcement on 6/17/22 that toxicology results now indicate a positive result for trace amounts of cocaine found within the child's system. As such, the manner of death may be changed. Law enforcement requested SCDSS not address these findings with the family at this time, as further investigation is needed.

SCDSS made several home visits and interviewed the verbal surviving sibling (age 7) and additional family collateral sources. All siblings (age 7 and 22-months) were assessed to be safe.

SCDSS made the appropriate determination and unsubstantiated the allegations against the father and babysitter regarding the death of the child. SCDSS found no preponderance of evidence that either adult caused or contributed to the death. At the time of case closing, there was no evidence to show that the trace amounts of cocaine found in the child's toxicology contributed to the child's death.

SCDSS offered the family information on bereavement counseling, mental health counseling, as well as other community resources they felt the family could benefit from. The mother, father, and surviving sibling (age 7) were engaged in counseling services at the close of the investigation.

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

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:
SCDSS made contact with family members and collaterals, including medical and LE. Regular case conferences were held to review casework activity. SCDSS supported their decision to unfound and close the investigation as there was not a fair preponderance of evidence to support the allegations against either SF or OA.

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: 04/22/2022 **Time of Death:** 10:10 AM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 10:02 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
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? 10 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **N/A**

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	Father	Alleged Perpetrator	Male	53 Year(s)
Deceased Child's Household	Mother	No Role	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	30 Year(s)
Other Household 1	Father	No Role	Male	39 Year(s)

LDSS Response

On 4/22/2022, SCDSS received a report regarding the death of SC. SCDSS initiated their investigation within 24 hours, coordinated with LE, and relevant medical staff. SCDSS learned the aunt in the report is a live-in babysitter (OA), unrelated to the family. SCDSS completed a CPS history check and informed the DA of the fatality. SCDSS assessed the safety of the SSs and conducted an initial home visit on the same date the report was received.

SCDSS interviewed all adults regarding the events leading up to SC's death. A timeline of SC's seizure history was provided. BM shared SC and twin were born at 36 weeks, were under five pounds, and SC was born not breathing. SC had been developing more slowly than her twin. The family denies any seizure activity since 3/22/22 and stated SC is followed

by a neurologist, last seen 4/12/22. The neurologist was attempting to determine if SC had a seizure disorder or febrile seizures. The morning of the incident, SF left for work at 7:00AM and OA was home with the children. BM was out of state. OA reported SC and the twin SS were put to bed at about 9-9:30PM on the evening of 4/21/22. OA did not recall anything different the evening before the incident. Both SC and the twin SS woke around 12-12:30AM for a bottle, which is normal. OA went into the bedroom when the twin SS woke, at approximately 9:30AM and noticed SC was still sleeping. BM confirmed it is normal for the twins to sleep until 9:30-10:00AM. When OA went to check on SC around 10:00AM, she noticed SC was blue. OA reported immediately calling 911 after finding SC unresponsive and starting CPR. This information was consistent with what LE reported SF and OA recounted. The FD responded but SC was not transported to the hospital. The ME's office arrived on scene as well.

SCDSS interviewed the verbal SS, along with additional family collateral contacts, none of whom had any additional information in relation to the incident. None of the family collateral contacts reported anything concerning to SCDSS. SSs appeared free from visible marks and bruises and were observed on multiple occasions.

SCDSS spoke with the ME on scene the day of the incident, who reported there were no signs of trauma, no marks or bruises and the SC appeared well cared for. The ME did not express any concerns of abuse or maltreatment. Vomit was observed on the sheets and around the mouth of SC, which the ME reported is consistent with a seizure. SC was found cold to the touch, with rigor mortis and lividity already present, consistent with a face down position. SCDSS inquired if it was possible for SC to choke on vomit if face down and the ME responded that it was possible. A preliminary autopsy report was requested and showed SC was a well developed and nourished child. No fractures, internal injuries, or disease were found. Very minor face abrasions and contusions were observed, although the ME reported these markings are not concerning for the age of the child. Preliminary toxicology screens were negative, however, upon follow up with LE, SCDSS learned toxicology screens later came back positive for cocaine. Preliminary autopsy findings stated it was either a seizure related death or related to prone sleeping in a crowded crib. Final cause of death was still pending and may be changed, and it was unknown if the cocaine was a factor in the death. LE requested SCDSS not address this with the family as they will be doing further investigation.

SCDSS contacted numerous collateral sources, which included LE, medical providers, and extended family members. Bereavement and counseling services were offered to the family, to which they were receptive. At the close of the investigation, the SSs were deemed as safe, and no criminal charges were brought against either subject of the report. SCDSS did not find a preponderance of evidence to support the allegations in the report, and appropriately unfounded 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: 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: 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
060621 - Deceased Child, Female, 1 Year(s)	060624 - Father, Male, 53 Year(s)	DOA / Fatality	Unsubstantiated
060621 - Deceased Child, Female, 1 Year(s)	060624 - Father, Male, 53 Year(s)	Inadequate Guardianship	Unsubstantiated
060621 - Deceased Child, Female, 1 Year(s)	060624 - Father, Male, 53 Year(s)	Lack of Supervision	Unsubstantiated
060621 - Deceased Child, Female, 1 Year(s)	060626 - Unrelated Home Member, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
060621 - Deceased Child, Female, 1 Year(s)	060626 - Unrelated Home Member, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
060621 - Deceased Child, Female, 1 Year(s)	060626 - Unrelated Home Member, Female, 30 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐
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	☒	☐	☐	☐

Explain:
All adults were provided with bereavement and mental health counseling referrals for themselves and the children. Due to a history of substance misuse among all adults, SCDSS provided referrals to relevant treatment providers. Although the SC's toxicology was positive for cocaine, active substance misuse was denied by the adults and not a noted safety concern throughout the investigation.

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?	☐	☒	☐	☐

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? Yes
Explain:
The parents were provided with bereavement resources for the surviving siblings. The parents indicated they will be utilizing bereavement services for the SS, age 7.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement, mental health, and outpatient substance misuse resources were provided to the parents and caregiver.

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?	Yes
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

Between 2016 and 2017, there were three unfounded cases against SF with common allegations of IG, IF/C/S and PD/AM. In 2017, there was one unfounded case against BM with allegations of EN, IG, PD/AM, and P/Nx.
Between 2017 and 2018, there were three cases against BM with recurring allegations of IG and PD/AM. The 2018 report was substantiated and opened for monitoring through a Family Services case.
Between 2017 and 2018, there were two cases against OA with common allegations of IG and PD/AM. The 2018 case was substantiated and opened for monitoring through a Family Services case.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Preventive Services History

BM, BF and SS (then age 3) were involved in a Family Services case, which opened 3/21/18. BM was cooperative with mandated preventive services and actively followed the case plan. At the time of the Family Services case, BF was not the primary caretaker to SS, nor did he wish to act as a primary caretaker. The documented service needs that warranted a preventive services case included the health and safety of the child, parent service needs, child service needs, and court-ordered placement. The agency responsible for case planning was SCDSS. All FASPs were completed, however, they were often completed late. SCDSS did not comply with casework contact requirements. The record reflects insufficient face-to-face contacts made with SS, as they were not seen twice monthly, and in April 2018, September 2018, December 2019, and March 2020 the record does not contain documentation of any face-to-face contact with SS. SC and her twin were born while the Family Services case was open. Records reflect a discussion of safe sleep practices but did not indicate if the newborns' sleeping arrangements were observed prior to closing the case. The Family Services case was closed 9/22/20, upon the expiration of court orders and BM's successful completion of court-ordered services.

Foster Care Placement History

SCDSS filed an Article 10 Neglect petition against BM due to BM's substance misuse while a sole caretaker to SS. SS (age 3 at the time) was removed 3/1/18 from BM and was directly placed with his MGM and MGF. BF to SS expressed that he did not wish to be a placement resource for his son. Fact finding was completed on 6/11/18 and a neglect finding was made against BM. SS remained in foster care until 9/19/19, at which time he was returned to BM's care. BM successfully completed court ordered services, including mental health services, substance misuse services, and a parenting skills program. Upon returning home, a one-year order of supervision was put in place and the family continued to be monitored by SCDSS through 9/22/20.

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