Child Fatality Report

Report Identification Number: SV-22-008

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

Issue Date: Aug 08, 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: 5 month(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 03/25/2022
Initial Date OCFS Notified: 03/25/2022

Presenting Information

An SCR report was received by Suffolk County Department of Social Services (SCDSS) on 3/25/2022. The report alleged the father returned home from work at approximately 6:20 AM on that day, and noted the child and mother sleeping in bed together. The father noticed the child's face was down in the mattress, turned the child over, and noticed that her lips were blue. The father performed CPR on the child and called 911. EMS arrived at the home at 6:25 AM, took over CPR, and transported the child to the hospital. The child was pronounced deceased at 7:59 AM.

Executive Summary

SCDSS initiated an investigation immediately upon receipt of the SCR report on 3/25/2022, and spoke with with the parents, other household members, hospital staff, law enforcement, and the mother's drug treatment provider. Contact was made with the family's preventive services caseworker, as the family had an ongoing Preventive Services Case at the time of the child's death. At the time of the death, the child resided in an apartment with the mother, father, maternal uncle, and a family friend. The apartment was attached to the home of the maternal grandmother and grandfather.

The child, mother, and father were engaged with a Preventive Services Case at the time of the child's death. SCDSS had filed a neglect petition against the mother on 12/9/2021, due to her failure to engage with substance abuse treatment after the birth of the child, at which time the mother and child were positive for illegal substances. The filing of the petition resulted in the child being placed with the father, and an order of protection was put in place directing that the mother be allowed only supervised contact with the child. SCDSS approved the father and the maternal grandparents as supervisors for that contact.

Through contact with the medical examiner, SCDSS learned the autopsy was completed on 3/26/2022, and there were no signs of trauma or abuse that contributed to the death. The medical examiner stated it was possible the child could have passed away from suffocation given the explanation of the incident; however, the final autopsy report was pending toxicology results.

SCDSS contacted law enforcement and learned they responded to the home and to the hospital on 3/25/2022 and spoke with the family, with hospital staff, and with the medical examiner. As of the closure of the CPS case, law enforcement reported their investigation was ongoing; however, they reported no concerns for criminality related to the death.

The mother's substance abuse treatment providers reported the mother had tested positive for illegal substances on 3/19/2022 and 3/22/2022 and was only sporadically engaged with her treatment.

The allegations of DOA/Fatality, Inadequate Guardianship, and Parent's Drug/Alcohol Misuse were substantiated against the mother. SCDSS determined the mother was aware of the dangers of co-sleeping with the child, was in violation of a court order stipulating that she not consume drugs or alcohol while caring for the child, and was in violation of a court order that she was to stay away from the child except for visitation supervised by approved supervisors.

The allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision were substantiated against the father. SCDSS determined the father was aware of the mothers recent relapse, that the mother was regularly co-sleeping with the child, and that the grandparents were not adequately supervising the mother and child overnight while he was at work.

The allegations of DOA/Fatality and Inadequate Guardianship were substantiated against both grandparents. SCDSS determined the grandparents were aware of the court order that the mother could not be unsupervised with the child, and had signed an agreement that they understood the need for, and agreed to provide, such supervision. The grandparents allowed the mother and child to be unsupervised overnight for a period of weeks, despite awareness of the mother's relapse.

The mother, father, and grandparents were referred to grief counseling services. After the death of the child, the Preventive Services Case was closed on 4/21/2022, as there were no surviving siblings. The fatality investigation was closed on 5/20/2022.

After the closure of the CPS investigation, but prior to the writing of this report, SCDSS received the final autopsy report which listed the cause of death as cocaine intoxication. SCDSS spoke with law enforcement at that time and learned the investigation had been referred to the homicide unit.

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?** 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:
The case was appropriately determined and closed as there were no surviving siblings or other children residing in the home.

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: 03/25/2022 **Time of Death:** 07:59 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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
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

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	Female	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	64 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	64 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)

LDSS Response

SCDSS initiated an investigation immediately upon receipt of the SCR report on 3/25/2022, and spoke with the subject parents, other household members, hospital staff, law enforcement, and the mother's substance abuse treatment provider. Contact was made with the family's preventive services caseworker, as the family had an ongoing Preventive Services Case at the time of the child's death.

The mother and father were interviewed separately. SCDSS learned the father left for work around 7:00 PM on 3/24/2022, leaving the child with the mother overnight. The mother reported she was awake with the child around 3:00 AM, fed the

child a bottle of formula, and put the baby to sleep on the mother's chest, where she was sleeping on a pull-out couch in the living room with a sheet, blanket, and 2 pillows. The mother stated she had been placing the child to sleep on the mother's chest as the child had been fussy due to teething. The father reported he arrived home sometime around 6:00 AM and saw the child laying face-down on the pull-out couch with the mother. The father became concerned when he noticed the child did not react to a loud noise, so he checked the child and found the child to be unresponsive and her lips were blue. Both parents reported the mother contacted 911 while the father administered CPR to the child.

There were no surviving siblings and no other children residing in the home.

The father and mother were questioned about their knowledge of safe sleep. Both reported being educated regarding safe sleep by the hospital at the child's birth, and by multiple caseworkers throughout their involvement with SCDSS. The father and mother had a bassinet and a crib for the child but were not utilizing either due to the child's fussiness.

All home members were questioned regarding the mother's substance abuse issues and reported being aware that the mother had relapsed in February 2022. All reported no knowledge that the mother had continued to use illegal substances after her relapse and denied any suspicion that the mother was under the influence of any illegal or non-prescribed substance at the time of the child's death.

The mother, father, and both grandparents stated it was a common occurrence that the mother would be left with the child overnight on the other side of the home. The grandparents stated they believed that to be appropriate supervision, as the door between the two sides of the home was left open.

SCDSS gathered records from and spoke to first responders. A report received from a responding EMT noted a piece of food was blocking the child's airway and was removed prior to resuscitation efforts. Upon speaking with that EMT, SCDSS was informed the EMT had come to believe the object blocking the child's airway was not a piece of food. The EMT described the object as a soft white object covered by a layer of thin, white paper. The EMT stated he believed this object could have been a nicotine pouch. The object was discarded during the events of the emergency response to the home and was not identified or found by any other first responders. SCDSS and law enforcement questioned all family members about the possibility of the child ingesting a nicotine pouch or similar object and all home members denied using or observing any such objects in the home. No home member was able to provide any explanation as to how the child could have ingested the object.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
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

060161 - Deceased Child, Female, 5 Mons	060162 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
060161 - Deceased Child, Female, 5 Mons	060162 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
060161 - Deceased Child, Female, 5 Mons	060163 - Father, Male, 32 Year(s)	DOA / Fatality	Substantiated
060161 - Deceased Child, Female, 5 Mons	060163 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
060161 - Deceased Child, Female, 5 Mons	060164 - Grandparent, Female, 64 Year(s)	DOA / Fatality	Substantiated
060161 - Deceased Child, Female, 5 Mons	060164 - Grandparent, Female, 64 Year(s)	Inadequate Guardianship	Substantiated
060161 - Deceased Child, Female, 5 Mons	060165 - Grandparent, Male, 64 Year(s)	DOA / Fatality	Substantiated
060161 - Deceased Child, Female, 5 Mons	060165 - Grandparent, Male, 64 Year(s)	Inadequate Guardianship	Substantiated
060161 - Deceased Child, Female, 5 Mons	060162 - Mother, Female, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
060161 - Deceased Child, Female, 5 Mons	060163 - Father, Male, 32 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief counseling was provided to all adults in the case composition.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)
10/24/2021	Deceased Child, Female, 1 Days	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 1 Days	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report dated 10/24/2021, alleged the SM and SC tested positive for cocaine and marijuana at the time of delivery and the SC exhibited withdrawal symptoms as a result.

Report Determination: Indicated
Date of Determination: 12/16/2021

Basis for Determination:
The SM obtained a substance abuse evaluation and agreed to enter into treatment; however, she missed multiple counseling sessions and failed to submit to toxicology screens as required by the treatment provider. The SM did submit a toxicology screen on 12/8/2021, and again tested positive for cocaine. A neglect petition was filed by SCDSS which resulted in a mandated service case.

OCFS Review Results:
SCDSS made contact with and interviewed all home members. Supervisory guidance is documented throughout the case record as is consultation with SCDSS's legal department. The record reflects there were missed opportunities to gather information from collateral contacts such as the child's pediatrician and other medical providers.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
SCDSS did obtain releases from the parents to speak with the child's pediatrician as well as a specialist for a medical condition unrelated to the fatality; however, contact with those collaterals was not documented during the 10/24/2021 investigation. SCDSS did contact, and document information gathered from those providers during the fatality investigation.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
SCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

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 is no known history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 12/16/2021

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 12/16/2021

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☒	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐
Additional information, if necessary: The preventive services were provided by SCDSS.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Adequacy of Child Protective Services casework contacts (open services)
Summary:	SCDSS made only 1 face-to-face contact with the family for the month of February, 2022.
Legal Reference:	18 NYCRR 432.2(b)(4)(vi)
Action:	In cases where the child protective service is the primary service provider to children named in indicated child protective services cases and their families, LDSS must make at least two separate face-to-face contacts per month with the subject(s) and other persons named in the report, one of which one must take place in the subject's home.

Preventive Services History

The family was opened for preventive services on 12/9/2021, due to ongoing concerns for the SM's drug use. The SM and SC had tested positive for marijuana and cocaine at the child's birth and the mother continued to test positive for cocaine without engaging in substance abuse treatment. SCDSS filed a petition in Family Court, which resulted in mandated preventive services. The SM was ordered to comply with substance abuse treatment and to not be unsupervised with the SC. The preventive services case was open at the time of the SC's death.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/09/2021	There was not a fact finding	There was not a disposition
Respondent:	060162 Mother Female 30 Year(s)	
Comments:	SCDSS filed a neglect petition against the SM due to her failure to engage with substance abuse treatment after she and the SC had a positive toxicology for illegal substances at the SC's birth. The subject child was placed in the custody of the SF with an order allowing the SM to have only supervised contact with the SC. After the SC's death, the petition was withdrawn prior to a fact-finding or disposition being made.	

Have any Orders of Protection been issued? Yes	
From: 12/09/2021	**To:** 04/21/2022
Explain: There was an order of protection in place which required the SM's contact with the SC to be supervised at all times. That order was vacated on 4/21/2022, after the SC's death.	

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