Child Fatality Report

Report Identification Number: SV-22-010

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

Issue Date: Sep 26, 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: 7 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 04/23/2022
Initial Date OCFS Notified: 04/23/2022

Presenting Information

An initial SCR report dated 4/23/2022, as well as subsequent and duplicate reports dated 4/24/2022, alleged the 7-month-old child sustained retinal hemorrhages, subdural hemorrhages, subarachnoid hemorrhages, and significant brain herniation while in the care of the subject father and paternal grandmother. The subject father and paternal grandmother provided different accounts of how the child was found. Neither the subject father nor paternal grandmother were able to provide any explanation for the injuries sustained by the child. The paternal grandmother contacted 911 and EMS responded to the home. The child was transported to the hospital where he was pronounced deceased. There were 16yo, 14yo, and 12yo paternal aunts residing in the home.

Executive Summary

This report concerns the death of the 7-month-old child that occurred on 4/23/2022 and was investigated by Suffolk County Department of Social Services (SCDSS). At the time of his death, the child resided with his mother, father, paternal grandmother, paternal step-grandfather, and his 12-year-old, 14-year-old, and 16-year-old paternal aunts.

The investigation revealed that on 4/22/2022, the father left the child sleeping face-down on the parents' queen-sized bed, went upstairs to speak with the paternal grandmother, went to the basement to get laundry, and returned to the bedroom to find the child had vomited on the bed. The father reported he was unsure for how long he had been out of the bedroom but believed it to have been about 5 minutes. The father picked the child up and noticed the child was limp. The father yelled for the paternal grandmother who contacted the paternal step-grandfather and contacted 911. The paternal step-grandfather returned home from around the corner and began to perform CPR on the child. EMS responded to the home and transported the child to the hospital.

During the child’s treatment at the hospital, medical staff found the child to have suffered a significant brain bleed, cerebral edema, and cardiac arrest. The child was kept on life support overnight. The parents were informed of the child’s poor prognosis and signed a DNR. The child was extubated on 4/23/2022 and declared deceased at 3:21 PM that day. Medical staff reported the child’s death was suspicious for abuse or maltreatment and stated the injuries to the child were unlikely to have been sustained through natural causes.

An autopsy was completed, and the medical examiner noted the preliminary cause of death was blunt force trauma to the head. The child was found to have retinal hemorrhaging and a skull fracture as well as bruising to the side and back of his head. The medical examiner stated the trauma most likely did not occur at the time the child became unresponsive and could have happened a few hours to a few days prior; however, someone would have noticed that the child seemed off during that time. The medical examiner stated the injuries were suspicious in nature absent an explanation as to how they occurred and noted the injuries could have been the result of the child being dropped accidentally. Regarding the brain bleed, the medical examiner stated that injury could have been caused by the blunt force trauma to the head or could have been chronic since birth and the medical examiner was awaiting a final report from a neuropathologist regarding the child’s brain and eyes. The medical examiner reported the final autopsy report was pending and would not be ready for some time.

The law enforcement investigation was ongoing at the time the CPS case was closed and law enforcement reported the child’s death was being investigated as a homicide. Law enforcement reviewed in-home surveillance camera footage and reported there was no conclusive evidence on the footage as to what caused the child’s injuries.

SCDSS assessed for the safety of the 12, 14, and 16-year-old paternal aunts throughout the investigation and found no immediate concerns for their safety.

The allegations of Internal Injuries and Inadequate Guardianship against the mother, father, and paternal grandmother and allegations of DOA / Fatality against the father and paternal grandmother only, were unsubstantiated. The record reflects there was not a preponderance of evidence to substantiate the allegations despite concerns the injuries leading to the child's death may have been inflicted. At the closing of the CPS investigation, SCDSS spoke with hospital staff, law enforcement, the medical examiner, and the district attorney and requested that any further concerning information or evidence of abuse regarding the fatality be reported to the SCR.

All family members were provided referrals for grief counseling and the investigation was closed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **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:
The level of casework activity was commensurate with the case circumstances. SCDSS made home visits as appropriate to investigate the fatality allegations and assess for the safety of the surviving children. Supervisory consultation was documented throughout the case record.

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: 04/23/2022 **Time of Death:** 03:21 PM

Date of fatal incident, if different than date of death: 04/22/2022
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? 5 Minutes

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	Aunt/Uncle	No Role	Female	16 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	14 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	12 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	18 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	38 Year(s)

Deceased Child's Household	Mother	No Role	Female	19 Year(s)

LDSS Response

SCDSS initiated an investigation immediately upon receipt of the SCR report on 4/22/2022, and spoke with all household members, hospital staff, law enforcement, the medical examiner, the district attorney, and the child's pediatrician.

Two SCR reports were received by SCDSS. The first was received on 4/22/2022 with allegations regarding the child's suspicious injuries and the second was received on 4/23/2022 after the child's death. The reports could not be merged due to the allegation of DOA / Fatality on the 4/23/2022 report; however, the cases were investigated simultaneously and contained substantively similar information.

Through investigation, SCDSS learned the father, paternal grandmother, and 3 paternal aunts were in the home when the child was found unresponsive by the father. Shortly before the death, the mother had left for work and the step-grandfather had left the home to go to the store. All household members were interviewed separately throughout the investigation, and none were able to provide an explanation for the injuries that led to the child's death.

The father reported that, upon finding the child unresponsive, he ran to the stairs to yell for the paternal grandmother who contacted the paternal step-grandfather. The father contacted the mother and rode in the ambulance with the child to the hospital. The mother traveled to the hospital herself upon learning of the incident.

SCDSS gathered records from the child's pediatrician which showed he was up to date with his scheduled well-visits and there were no concerns for his health or safety in the care of his parents.

The paternal aunts were interviewed and had their safety assessed throughout the CPS investigation. The children reported being distraught over the death of their nephew. The children reported that, while they were home at the time the child was found unresponsive, they were not present when the child was found and have no knowledge of any person harming the child. SCDSS provided the grandparents with grief counseling information and followed up throughout the case, however, the grandparents reported being unsure if they would utilize those services.

SCDSS further assessed the safety of the paternal aunts by making contact with the children's school and pediatrician, all of whom reported no specific concerns for the children's health or safety in the care of the grandparents.

The parents were questioned regarding safe sleep and reported they regularly placed the child face-down in the adult bed with them to sleep. The father similarly reported the child was placed face-down on the adult mattress prior to being found unresponsive. SCDSS discussed safe sleep practices with all family members. The parents were questioned regarding alcohol and drug use, and both denied any alcohol or drug use for themselves or for any other home member.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Suffolk County does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060836 - Deceased Child, Male, 7 Mons	060839 - Grandparent, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
060836 - Deceased Child, Male, 7 Mons	060839 - Grandparent, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
060836 - Deceased Child, Male, 7 Mons	060839 - Grandparent, Female, 38 Year(s)	Internal Injuries	Unsubstantiated
060836 - Deceased Child, Male, 7 Mons	060840 - Father, Male, 18 Year(s)	DOA / Fatality	Unsubstantiated
060836 - Deceased Child, Male, 7 Mons	060840 - Father, Male, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
060836 - Deceased Child, Male, 7 Mons	060840 - Father, Male, 18 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?	☒	☐	☐	☐

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:
Bereavement referrals were made for all family members. SCDSS discussed bereavement services with the family multiple times and the family reported they were unsure they would engage with those services.

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:
SCDSS provided referrals for grief counseling for all household members.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS provided referrals for grief counseling for all household members.

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

The paternal grandmother was reported to the SCR as the subject of maltreatment to her children 5 times between 2001 and 2019. She had been an indicated subject 2 times. There was a CPS investigation in 2001 regarding unexplained traumatic injuries to the paternal grandmother's then infant child, resulting in allegations of Fractures and Inadequate Guardianship being substantiated against all adult household members including the paternal grandmother. There was a CPS investigation in 2015 regarding concerns for the grandmother's mental health including multiple hospitalizations due to suicidal ideation, as well as concerns for the grandmother engaging in physical altercations in the presence of her children, with the children interfering in at least one of those incidents.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

From 2/2/2016 to 3/30/2016, preventive services were provided to the paternal grandmother and paternal step-grandfather as well as the 16, 14, and 12-year-old aunts who reside in the home. The grandparents agreed to a voluntary preventive services case due to concerns for the grandmother's multiple mental health hospitalizations as well as domestic violence including physical fighting in which the children intervened. The voluntary preventive services case closed in less than 2 months as the family was non-cooperative.

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.

Additional Local District Comments

Suffolk County Department of Social Services has reviewed the report and concurs with OCFS.

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