Child Fatality Report

Report Identification Number: SV-24-051

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

Issue Date: Apr 01, 2025

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 29 day(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 11/13/2024
Initial Date OCFS Notified: 11/13/2024

Presenting Information

An SCR report alleged on 11/12/24, at about 11:00 PM, the mother fell asleep while holding the 29-day-old child. On 11/13/24, at about 3:00 AM, the mother woke up and found the child was not breathing and did not have a pulse. The grandmother performed CPR, and the mother called 911. EMS arrived and transported the child to the hospital where he was pronounced deceased at 4:00 AM. It was believed the unsafe sleeping environment contributed to the death.

Executive Summary

This report concerns the death of the 29-day-old child that occurred on 11/13/24. Three SCR reports were received on the same day that alleged the mother fell asleep while holding the child and hours later, she found the child unresponsive and not breathing. The child subsequently died. At the time of his death, the child resided with his mother, paternal grandmother, great-grandparents, paternal aunt (4), paternal uncle (13) and siblings, aged 2, 3 and 5 years. The children were assessed to be safe. The father resided outside of the home and did not have information regarding the death.

Suffolk County Department of Social Services (SCDSS) coordinated investigative efforts with law enforcement. Law enforcement anticipated closing their investigation without charges filed. An autopsy was performed; however, the autopsy report was not yet available at the time of this writing. The medical examiner reported there was no overt trauma to the child, and stated the unsafe sleeping environment was a contributing factor of the death.

The mother was interviewed and reported falling asleep on the couch with the child in her right arm. The mother later woke to find the child unresponsive and not breathing. The mother called 911 while the grandmother performed CPR until first responders arrived, took over lifesaving measures and transported the child to the hospital where he was pronounced deceased. It remained unknown whether the child's face was covered or if there were items on the couch.

SCDSS made collateral contact with the fathers of the children, a hospital doctor, and the pediatrician. There were no concerns for the mother's care of the children.

SCDSS completed required reports and Safety Assessments timely and with accuracy. Although seen face-to-face, the record did not reflect thorough interviews were conducted with the grandmother, great-grandparents, 5-year-old sibling, or paternal uncle. It remained unknown who was present at the time of the fatal incident or what may have happened prior to or after the mother found the child unresponsive.

The allegations of Inadequate Guardianship and DOA/Fatality were substantiated. The Investigation Conclusion Narrative stated there was a fair preponderance of evidence that the child was placed at imminent risk of physical, mental and emotional impairment which led to his death. There was evidence that the mother regularly slept on the couch with the child despite having a bassinet for the child. Furthermore, information gathered from the medical examiner's office included that "co-sleeping is a contributing factor to the infant's death and will be noted as such."

The family was offered bereavement services and funeral assistance, which were accepted. The investigation was appropriately determined and closed timely on 12/18/24.

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

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 investigation 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:
Casework activity was not commensurate with case circumstances as the record did not reflect multiple individuals on the case were interviewed regarding the fatal incident.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:	Although seen face-to-face, the record did not reflect comprehensive interviews with the paternal grandmother, the great-grandparents, the 5-year-old sibling or the 13-year-old uncle with regard to the fatal incident.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	SCDSS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/13/2024 **Time of Death:** 04:00 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: 03:05 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ 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	3 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	13 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	29 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	43 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Other Adult - Great-Grandfather	No Role	Male	57 Year(s)
Deceased Child's Household	Other Adult - Great-Grandmother	No Role	Female	68 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Father	No Role	Male	21 Year(s)
Other Household 1	Other Adult - Father of 13yo PU	No Role	Male	54 Year(s)
Other Household 2	Other Adult - Father of 2 and 3yo SSs	No Role	Male	23 Year(s)

LDSS Response

On 11/13/24, SCDSS received the fatality report and 3 subsequent reports from the SCR. Within the first 24 hours of the investigation, SCDSS contacted the sources of the reports, completed a CPS history check, coordinated investigative efforts with law enforcement and notified the ME and DA's offices of the death. The safety of the children was assessed.

On 11/13/24, a home visit was made, and the mother was interviewed. The mother reported that she fed the child around 11:00 PM on 11/12/24 and they slept together on the couch. Around 3:00 AM on 11/13/24, the mother woke and found the child unresponsive and not breathing. The child was found on her back in the mother's right arm, which was how she was placed to sleep. The mother reported she called 911 while the parental grandmother performed CPR. The mother reported that she and the child always slept together on the couch. Although present at the time the mother was interviewed and a supervisory note reflected the grandmother and great-grandparents were interviewed regarding the fatal incident, details of the interviews were not documented. It remained unknown who was present at the time of the fatal incident and information regarding the fatal incident from the perspectives of those individuals was not documented. The record noted the "adults deny any current substance us or abuse issues, or mental health concerns." Further information was not documented to have been explored.

The uncle denied there was concern in the home and stated that he felt safe. Further information was not documented to have been explored with him. The 5-year-old sibling reported he felt safe and that his brother was "taken away." A progress note reflected that the children were observed and interviewed; however, the record did not contain conversations regarding how overall safety and risk was measured. Due to their ages, the aunt and youngest siblings were not interviewed. The record reflected the children did not disclose child welfare concerns; however, the record did not reflect the verbal children were asked about the fatal incident.

SCDSS appropriately determined the allegations and closed the investigation timely.

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
070056 - Deceased Child, Male, 29 Day(s)	070057 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
070056 - Deceased Child, Male, 29 Day(s)	070057 - Mother, Female, 22 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?	☒	☐	☐	☐

Additional information:

The record did not reflect the 5-year-old sibling, 13-year-old uncle, grandmother or great-grandparents were interviewed regarding the fatal incident or possible events leading up to the death.

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	☐	☒	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
The children did not need to be removed.

Legal Activity Related to the Fatality

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

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The record did not reflect family planning was offered to the mother despite having four children.

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:

The family was offered grief services for the children in response to the fatality. The adults were open to utilizing the referrals.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The family was offered grief services in response to the fatality. The adults were open to utilizing the referrals.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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

12/14/17-03/28/18 The PGM was unsubstantiated for IG of 2 other children.

08/19/19-10/04/19 The PGM and father of her children were unsubstantiated for IG and CD/A of 2 other children.

Known CPS History Outside of NYS

SCDSS appropriately attempted to obtain possible CPS information from a state the mother and children previously resided to no avail. There is 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