Child Fatality Report

Report Identification Number: SV-24-052

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: 3 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 12/03/2024
Initial Date OCFS Notified: 12/03/2024

Presenting Information

An SCR report alleged on 12/03/24, at about 1:55 AM, the mother was co-sleeping in bed with the 3-month-old child. The mother woke up to find the child was not breathing and she called 911. EMS arrived and administered CPR. It was believed that the unsafe sleeping environment contributed to the death. A 1034-investigation was ordered on 12/11/24, after the grandmother filed a Petition against the parents in an effort to obtain custody of the sibling.

Executive Summary

This report concerns the death of the 3-month-old child that occurred on 12/03/24. A report was made to the SCR on the same day alleging the mother was bedsharing with the 3-month-old child and later woke to find the child not breathing. The child was later declared deceased. The fatality report was subsequent to an SCR report that was received on 11/22/24 alleging the mother was impaired and acted erratically while caring for the children. At the time of the death, the child resided with his mother, grandmother, and twin sibling. The sibling was assessed to be safe.

Suffolk County Department of Social Services (SCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The criminal case was closed without criminality. An autopsy was performed; however, the report was not yet available at the time of this writing. The medical examiner noted there were no signs of trauma and that the death “looks like the result of a co-sleeping situation.”

The mother was interviewed and reported the child and sibling were fussy in the overnight hours and she brought them into bed with her before she unintentionally fell asleep. The mother woke around 1:40 AM and found the child unresponsive and not breathing. She screamed, which alerted the grandmother. The grandmother called 911 and performed CPR at the instruction of the 911 dispatcher. First responders arrived, took over lifesaving measures and transported the child to the hospital where she was pronounced deceased. The grandmother’s recollection of the fatal incident was consistent with what the mother had reported, aside from the grandmother reporting the sibling was in his bassinet.

SCDSS made collateral contact with the pediatrician, EMT and the mother’s psychiatrist. They did not have concerns for the care the mother provided to the children. The father did not reside in the home. He did not have concerns regarding the mother and noted that she was a great mother and was committed to the children.

On 12/11/24, the grandmother filed for emergency custody of the sibling in Family Court; however, the mother retained custody of the sibling. As a result, on 12/11/24, a 1034-investigation was ordered and was consolidated into the investigation that was open at the time of death. The mother and sibling moved out of the grandmother’s home and into the home of the grandfather. The 3-year-old uncle also resided in that home. There were no concerns for the safety of the children.

Safety Assessments and required reports were completed timely. The Safety Assessments were completed inaccurately as they reflected the sibling was significantly vulnerable due to his age and that the mother was unable and/or unwilling to provide adequate care and/or protection of the sibling. However, the progress notes did not reflect that the mother was unwilling or unable to protect the sibling, and the Safety Assessments noted the mother tended to the sibling’s needs and

was rational in her thought process. The Safety Assessment due at the time of determination inaccurately noted the sibling was in immediate or impending danger of risk or harm. Notice of Indication was not provided to the adults.

SCDSS added the allegation of Inadequate Guardianship regarding the sibling. The allegations of Inadequate Guardianship and DOA/Fatality were substantiated against the mother. The Investigation Conclusion Narrative reflected the mother was aware of the dangers of bedsharing yet placed the children at risk of harm by placing them in the bed with her. There was reasonable cause to suspect that the actions or inactions of the mother contributed to the death of the child.

SCDSS offered the family bereavement counseling, burial assistance and housing referrals. The mother accepted the services and was already engaged in mental health counseling. A Preventive Services Case was opened to assist the mother. The investigation was closed timely on 01/16/25.

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?** No

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 case remained open for Services.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The Safety Assessments were completed inaccurately as Safety Factor #16 was selected. The Safety Assessment due at the time of determination inaccurately noted the surviving children were in immediate or impending danger of serious harm. Notice of Indication was not provided. The issues were cited in the investigation that was open at the time of the death.

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: 12/03/2024 **Time of Death:** 03:25 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: 01:40 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	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	61 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)

Deceased Child's Household	Sibling	Alleged Victim	Male	3 Month(s)
Other Household 1	Father	No Role	Male	39 Year(s)

LDSS Response

On 12/03/24, SCDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, SCDSS coordinated investigative efforts with law enforcement, contacted the source of the report, completed a CPS history check and notified the ME and DA's offices of the death. The sibling was assessed to be safe.

On 12/03/24, SCDSS interviewed the grandmother. The grandmother reported she saw the mother sleeping on the couch with the children in the past and told her that it was not safe. She reported that the twins each had their own bassinet. On the morning of the fatal incident, the grandmother awoke to the mother screaming. She stated that the child was blue, cold to the touch and was unresponsive. The grandmother attempted to revive the child, and the mother called 911. First responders arrived and transported the child to the hospital where he was pronounced deceased. The grandmother noted the mother may have been abusing a prescription medication. The grandmother said the mother took good care of the children.

On 12/04/24, the mother was interviewed. She said she had been awake for the 3 nights prior to the death and that she was exhausted. The mother recalled on 12/02/24, she fed the children around 10:30 PM and placed them in their bassinets. Around 11:30 PM, the children were fussy, so she put them in bed with her and intended on feeding them. She went into the kitchen and when she came back to check on the children, the child was blue and limp. The mother reported rubbing the child's chest and performing rescue breaths. The mother's recollection was consistent with the grandmother's recollection, aside from the sibling also being in the bed.

Law enforcement provided the dispositions they collected. The mother's disposition was consistent with the information that was reported to SCDSS.

During the investigation, the grandmother filed a Petition in Family Court requesting emergency custody of the sibling. The grandmother reported having concerns for the mother's mental health and drug use. A 1034-investigation was conducted and did not reveal evidence to support the grandmother's concerns, and the mother retained custody of the sibling.

SCDSS contacted the mother's psychiatrist who did not have concerns for the mother and did not believe the mother was misusing her prescription medication. The investigation revealed the mother had not used drugs for years prior to the death, and that she maintained her sobriety.

SCDSS appropriately determined the allegations and closed the investigation. A Preventive Services Case remained open at the time of this writing.

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
070202 - Deceased Child, Male, 3 Month(s)	070204 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
070202 - Deceased Child, Male, 3 Month(s)	070204 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
070203 - Sibling, Male, 3 Month(s)	070204 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☐	☒
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐

Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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:
No children needed to be removed.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/10/2024	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The MGM filed a Petition against the parents to obtain emergency custody of the sibling. A 1034-investigation was conducted, and custody remained with the mother.	

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	☐	☐	☐	☐	☐	☒

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 adults were offered bereavement services, funeral assistance and mental health counseling. The mother accepted the services and was already engaged in mental health services. The mother accepted funeral assistance, and housing assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/22/2024	Sibling, Male, 3 Months	Mother, Female, 30 Years	Other	Unsubstantiated	Yes
	Sibling, Male, 3 Months	Grandparent, Female, 61 Years	Other	Unsubstantiated	
	Sibling, Male, 3 Months	Father, Male, 39 Years	Other	Unsubstantiated	

Sibling, Male, 3 Months	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 3 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 3 Months	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 3 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged that on a regular basis, the SM drank to the point of impairment while acting as the sole caretaker of the SC and his twin. While intoxicated, the SM acted in a neurotic and aggressive manner. She had a history of alcohol and drug misuse. It was unknown if the SM used drugs at the time of the report. On 12/11/24, a subsequent report was made as the MGM filed a V-Docket Petition against the parents on behalf of the SS, resulting in a 1034-investigation regarding the SM, BF and MGM.

Report Determination: Indicated | **Date of Determination:** 01/16/2025

Basis for Determination:
The Investigation Conclusion Narrative stated the mother had a substance abuse history yet was sober since 2020. The mother's treatment provider did not express concern. During the investigation, the child died, and the ME noted the death appeared to be "co-sleeping related." The mother retained custody of the sibling.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely. The Safety Assessment completed at the time of determination was inaccurate. The RAP noted the SM understood the dangers of bedsharing and was receptive to recommendations regarding the SS. Notice of Indication was not provided.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
The Safety Assessment noted the SS was significantly vulnerable due to his age and the concerns for the SM possibly bedsharing, but that would reflect risk. The Safety Assessment noted the SS was safe in the care of the SM and that she was very attentive to his needs. The record noted the SS was not in immediate or impending danger.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:
Failure to Provide Notice of Indication

Summary:
The record did not reflect Notice of Indication was provided.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:

Within 60 days, whether a report assigned to the investigative track is "indicated" or "unfounded", and if "indicated", SCDSS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

[redacted]

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There 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