Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-17-040

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

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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		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 10/07/2017
Initial Date OCFS Notified: 10/09/2017

Presenting Information

An SCR report was received on 10/7/17 which alleged SF found SC face down and unresponsive in his crib at 4AM that same date. SC was pronounced deceased, and was an otherwise healthy child with no known medical issues. SC's cause of death was unknown.

Executive Summary

This fatality report concerns the death of a 1-month-old male child (SC) that occurred on 10/7/17. A report was made to the SCR on that same date, with allegations of DOA/Fatality and IG against the child's mother (SM) and father (SF). Suffolk County Department of Social Services (SCDSS) conducted an investigation into the child's death. An autopsy was performed; however, at the time of this writing, the results remained pending.

The child was considered otherwise healthy at the time of his passing with no preexisting medical conditions. He resided with his mother and father; there were no surviving siblings or other children in the household. It was discovered the night before the child's death, he was acting normally and appeared well. He was last fed at approximately 12:30AM on 10/7/17, and then placed to sleep in his crib, on top of a blanket that covered the mattress. The child was dressed in a fleece swaddle, and put on his side to sleep by his father. The parents reported placing the child on his side in his crib was their regular practice, despite having been educated surrounding safe sleep positioning. At approximately 4AM, the father checked on the child and found him face down, unresponsive. There was also blood underneath his nose and on the blanket. The mother called 911 and EMS responded to the scene. The child was transported to the hospital, where he was pronounced deceased.

SCDSS completed interviews with the child's parents and observed their home; there were no concerns noted. The parents refused to sign releases of information for collateral contacts, therefore SCDSS was unable to gather information from first responders. SCDSS did communicate often with law enforcement and the medical examiner, and also spoke with the child's pediatrician. Community based service referrals were provided to the parents prior to the close of the investigation. All assessments and reports were completed accurately and timely. SCDSS unsubstantiated the allegations in the report due to finding no evidence of abuse or maltreatment.

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

Explain:
SCDSS gathered sufficient information to determine the report. There were no SS or other children in the household whose safety needed to be assessed.

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 casework was commensurate with the case circumstances. SCDSS did not gather any credible evidence to support the allegations in the report, and therefore appropriately unsubstantiated and closed the investigation.

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: 10/07/2017 **Time of Death:** Unknown

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? 3 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not impaired.

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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

On 10/7/17, SCDSS received a report regarding the death of SC. SCDSS initiated their investigation within 24 hours, and coordinated their efforts with LE. SCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the District Attorney of the fatality. SCDSS learned there were no surviving siblings or other children that resided in the household at the time of SC's death.

From the time the investigation began until November 2017, SCDSS diligently attempted to meet with SM and SF via unannounced home visits and phone calls to schedule face to face interviews; however, the parents were not cooperative. As a result, SCDSS spoke with numerous collateral sources to gather information surrounding SC and his death. LE informed SCDSS the parents reported SC was born healthy with no underlying health conditions, and the night before his death, was acting normal and appeared fine. At 12:30AM on 10/7/17, SC was fed and then swaddled in a gray fleece. He was placed to sleep on his side in his crib, on top of a blanket. At approximately 4:20AM, SM reported to LE he went to check on SC, and found him on his stomach in his crib, with his face pressed into the blanket and crib mattress. SF also reported to LE that SC had blood under his nose. SF then woke up SM and she called 911. EMS responded to the home and transported SC to the hospital, where he was pronounced deceased. LE was able to perform a re-enactment with the parents, and supplied SCDSS with photographs of such. The photographs also showed the home environment, from which SCDSS noted no observable safety concerns or hazards.

SCDSS spoke with the ME several times throughout the investigation. At the time of this writing, a final autopsy report had not yet been issued; however, the ME informed SCDSS the cause of death would most likely be ruled Sudden Unexplained Infant Death. The ME had additional concerns that overheating may have played a role in SC's death, due to the amount of clothing the child was swaddled in when put to sleep, coupled with the child being found face down on a soft surface.

SCDSS met with the parents face to face on 11/28/17. Their accounts of the events leading up to SC's death were consistent with what they informed LE. The parents reported they were educated surrounding safe sleep practices, and it was normal for them to lay SC to sleep on his side because they feared he would choke if he spit up. SCDSS provided the parents with bereavement referrals, which they expressed interest in.

SM and SF refused to sign any releases of information which inhibited SCDSS from speaking with EMS first responders; they refused to speak with SCDSS without a signed consent. The pediatrician was spoken with, and expressed some concerns that SC had jaundice at his last two medical appointments. SCDSS followed up with the ME regarding this, and was informed jaundice in a newborn was considered normal, and it did not contribute to SC's death.

By the close of the investigation, LE informed SCDSS no criminal charges would be brought against either parent. SCDSS reviewed the case on more than one occasion with supervisors as well as the SCDSS MDT, prior to closing the case. It was noted by the ME that SC had no evidence of trauma to his body, and laboratory results showed no indications of dehydration, virus, or illicit drug intoxication. SCDSS appropriately unfounded the investigation and closed.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: This fatality investigation was conducted by the Suffolk County MDT.

Was the fatality reviewed by 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
044569 - Deceased Child, Male, 1 Mons	044572 - Father, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
044569 - Deceased Child, Male, 1 Mons	044573 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
044569 - Deceased Child, Male, 1 Mons	044573 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
044569 - Deceased Child, Male, 1 Mons	044572 - Father, Male, 30 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
SCDSS contacted an array of collateral sources to gather information surrounding SC's death. The parents refused to sign releases of information, and therefore SCDSS was unable to speak with EMS first responders.

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.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
SCDSS offered the parents service referrals in response to SC's death, and both accepted the referrals but ultimately declined services.

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? N/A
Explain:
There were no SS or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered to the parents as a result of the fatality, but both parents declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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? N/A
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

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

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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