



Report Identification Number: SV-20-051

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

Issue Date: May 25, 2021

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: 1 month(s)

Jurisdiction: Nassau
Gender: Female

Date of Death: 12/05/2020
Initial Date OCFS Notified: 12/07/2020

Presenting Information

An SCR report was received regarding the death of the 6-week-old subject child. The report alleged the father fed the child and placed her in her bassinet to sleep, but she became fussy. The father then took the child into bed with him and she fell asleep on the father's chest. The father then placed the child in-between himself and the mother, who was also in the bed. When the mother awoke, she found the child unresponsive underneath the comforter. Another adult in the home called 911. The child was transported to the hospital where she was pronounced deceased. The child was otherwise healthy and there was no explanation for her death.

Executive Summary

This fatality report concerns the death of a six-week-old male subject child that occurred on 12/5/20. A report was made to the SCR on 12/7/20 with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother and father. Nassau County Department of Social Services (NCDSS) received the report and investigated the child's death. An autopsy was completed; however, the cause and manner of death remained pending at the time of this writing.

At the time of the child's death, she resided with her mother, father, great-grandmother, and great-uncle. There were no surviving siblings or other children in the household. The investigation revealed that in the early morning hours of 12/5/20, the child was fed and then placed her in her bassinet. The child became fussy, so the father brought the child into bed with him and the mother, and laid the child on his chest. After the child fell asleep, the father placed her in-between himself and the mother, and they fell asleep as well. Approximately one hour later, the mother awoke to find the child unresponsive underneath the comforter that had been on the bed. She woke the father and both yelled for help; the great-uncle called emergency services. An ambulance arrived shortly after and transported the child to the local hospital, where she was pronounced deceased at 8:13AM.

From the time the investigation began to the time of its closure, NCDSS attempted to interview and engage with the family on numerous occasions without success. The family had attained legal representation, and their attorney informed NCDSS they would not cooperate with the investigation. NCDSS spoke with collateral sources to gather information surrounding the fatality, which included law enforcement, emergency medical technicians, the district attorney, and the medical examiner's office. There was no criminality found on behalf of the parents regarding the death of the child. The record did not reflect if the parents had been educated surrounding safe sleep practices, or other specific information pertaining to the fatal incident due to the parents' refusal to be interviewed. NCDSS documented there were aggravating factors which contributed to the child's death, such as multiple people on the same sleeping surface and loose bedding surrounding the child. Therefore, NCDSS substantiated the allegations in the report, and closed the investigation.

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? N/A

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:

NCDSS gathered evidence to determine the allegations. There were no surviving siblings or other children in the household.

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 record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

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: 12/05/2020

Time of Death: 08:13 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Nassau

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? 1 Hours

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	Male	22 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	53 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

On 12/7/20, NCDSS received the SCR report concerning the death of SC. NCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. It was learned there were no surviving siblings or other children that resided in the household.

On 12/8/20, NCDSS attempted to meet with the family at their home; however, the parents would not participate in interviews and expressed they would not cooperate with the CPS investigation. SF advised NCDSS to gather the information that was needed through statements the family had already given to LE. NCDSS made several attempts to meet with the parents face to face throughout the investigation but were unsuccessful. NCDSS consulted their legal department and were advised there was no legal action that could be taken as there were no other children in the home.

NCDSS obtained information regarding the fatality from the district attorney (DA). NCDSS was informed LE completed a walk-through of the case address and there were no safety hazards noted. LE reports noted the parents and SC resided with the maternal great-grandmother and great-uncle. SM informed LE that SC was born six weeks prematurely and was released from the hospital three weeks prior to her death. At the time of her release, she had been gaining weight and appeared healthy. The DA explained SC had some congestion on 12/3/20 which had been resolving itself with the use of a humidifier. SC also had some issues with feedings and recently changed formulas. The parents reported to LE that SC was being seen weekly by her pediatrician. The DA reported that on 12/5/20, SC was fed, changed, and placed in her bassinet. The parents explained SC was fussy and would not settle, so SF brought SC into bed with him and she eventually fell asleep. SF then placed SC in-between himself and SM, and the parents also fell asleep. The DA explained approximately one hour later, SM awoke to find SC underneath the comforter and unresponsive; the great-uncle's girlfriend heard SM screaming and called 911 while SF began CPR. The DA stated SC was pronounced deceased at the hospital, and an autopsy was completed. The record did not reflect specific times events occurred.

NCDSS spoke with the ME's office several times during the investigation. Each time, NCDSS was informed the results of the autopsy were pending; however, there were no signs of abuse or trauma found during the examination.



On 12/9/20, NCDSS spoke with LE who noted all family members were interviewed and all of their stories were consistent.

Throughout the investigation, NCDSS spoke with the attorney representing the parents. NCDSS' legal department submitted a written request to the parents' attorney requesting an interview with all family members. The attorney replied and noted his clients would not participate in any interviews or cooperate with CPS. NCDSS also spoke with EMS first responders who explained the parents were appropriately upset upon their arrival to the home and no one appeared to be under the influence of drugs or alcohol. There were no criminal charges brought against either parent regarding SC's death. NCDSS concluded the parents' actions placed SC in imminent risk of harm, and therefore indicated and closed the case.

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

Comments: This fatality investigation was conducted by the Nassau County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

Comments: This fatality was reviewed by the Nassau County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057008 - Deceased Child, Female, 1 Mons	057010 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
057008 - Deceased Child, Female, 1 Mons	057010 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
057008 - Deceased Child, Female, 1 Mons	057009 - Mother, Female, 19 Year(s)	DOA / Fatality	Substantiated
057008 - Deceased Child, Female, 1 Mons	057009 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Members	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

NCDSS made numerous attempts to complete interviews with family members; however, the family would not engage. NCDSS spoke with collateral sources and there was timely entry of progress notes and all 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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Parenting Skills	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Domestic Violence Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Early Intervention	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Child Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Additional information, if necessary:
 NCDSS was unable to offer services to the family as the family was advised by their attorney not to cooperate with the investigation.

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? No

Explain:
 There were no surviving siblings 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:
 The family would not cooperate with the investigation.

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? N/A
- Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

- Had medical complications / infections
- Had heavy alcohol use
- Misused over-the-counter or prescription drugs
- Smoked tobacco
- Experienced domestic violence
- Used illicit drugs
- Was not noted in the case record to have any of the issues listed

Infant was born:

- Drug exposed
- With fetal alcohol effects or syndrome
- With neither 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

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

Known CPS History Outside of NYS

There was 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