Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-008

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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 02/12/2021
Initial Date OCFS Notified: 02/12/2021

Presenting Information

The Westchester County Department of Social Services received an SCR report on 2/12/21 which alleged that on 2/11/21, the mother left the 1-month-old subject child in the care of the father. The father and the child were co-sleeping in the same bed while the mother went to the store. When the mother returned from the store, the father was still sleeping but the child was unconscious, not breathing, and he was bleeding from the nose. Emergency services were called and responded to the scene at 11:15PM. Law enforcement performed CPR on the child. The child was transported to the hospital where he was pronounced deceased. It was suspected that the co-sleeping contributed to the child's death. The mother condoned the father's action of co-sleeping with the child. As a result both the mother and the father were named subjects of this report.

Executive Summary

On 2/12/21, Westchester County Department of Social Services (WCDSS) received an SCR report regarding the death of the 1-month-old male subject child that had occurred on the same day. The child resided with his mother, father, grandmother and aunt.

WCDSS learned that leading up to the fatality the child was left in the care of the father while the mother was shopping. Before the mother left the home, she placed the child in an adult sized bed on his back with pillows. The father was lying at the bottom of the bed. It was unclear from the interviews if he was awake or asleep. The father was exhausted after attending a double session of barber school. The mother left the child with the father for approximately an hour and a half. When the mother returned, she discovered the child on his stomach with his face pressed into the mattress and he was unresponsive. The father was asleep and in the same position as when the mother left. Emergency services were called and responded to the scene. Law enforcement performed cardio pulmonary resuscitation on the child. The child was transported to the hospital where he was pronounced deceased at 12:23AM.

An autopsy was performed, and the manner of death was undetermined. The cause of death was asphyxia due to unsafe sleep in an adult bed with the father. The autopsy report showed that there was no evidence of external or internal injuries.

The allegation of Internal Injuries was unsubstantiated due to the autopsy examination indicating the child showed no signs of internal injuries. WCDSS substantiated the allegations of DOA/Fatality and Inadequate Guardianship as they determined that the parents' actions and decisions were neglectful and contributed to the child’s death. WCDSS made a referral for the family to victim's assistance program for bereavement counseling and funeral assistance; however, the family was not receptive to the service providers outreaches. The CPS investigation was closed on 4/13/21.

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

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:
WCDSS determined there was no need for further CPS involvement and closed their 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: 02/12/2021 **Time of Death:** 12:23 AM

Date of fatal incident, if different than date of death: 02/11/2021
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Westchester
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? N/A
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? Unknown if they were impaired.
At time of incident supervisor was:

☐ Distracted
☒ Asleep
☐ Absent
☐ 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	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	19 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

WCDSS investigated the incident by searching SCR history and speaking to the mother, grandmother and aunt. They made collateral contacts with law enforcement, the medical examiner and the pediatrician.

WCDSS interviewed the mother who reported on the day leading up to the child's death the father attended back to back sessions of barber school from 9:00AM to 8:00PM and stated the father was exhausted. While the father was at school, the mother asked the grandmother to watch the child so the mother could shop for the birthday celebration she was planning for the father the following day. The mother returned home around 3:30PM and then left with the child and the aunt to do additional shopping. The mother, child and aunt returned home around 8:00PM. The aunt fed the child and the mother burped him. The mother changed the child’s diaper and then laid him down on her bed on his back. The child’s crib was next to the parents’ bed. The mother placed pillows against the wall near the bed because there was an opening and she did not want to risk the child bumping his head on the wall. The mother reported that the child was lying next to the pillows. The father was also lying on the bed along with the child, but he was positioned at the end of the bed and was nowhere near the child. The mother then left the home and returned around 11:00PM. When she entered the bedroom she saw that the father was in the same spot at the bottom of the bed and asleep. The child was closer to the headboard at the top of the bed and was on his stomach with his face pressed into the mattress. The mother turned the child over and he was lifeless with a little bit of blood under his nostrils. The family called 911. WCDSS attempted to interview the father; however, he reported he was advised by his attorney to not speak with CPS and declined to be interviewed throughout the investigation.

The grandmother confirmed she was home at the time of the child's death, but she was sleeping the majority of the time while the mother was out. At an unknown time, the grandmother walked past the bedroom door and listened, but only heard snoring coming from the room. She did not hear anything that would have suggested that the child was in distress. The grandmother said she was asleep until the mother returned home. The grandmother reported the mother and father were good parents. She stated that the father was not near the child on the bed and was not responsible for the child suffocating.

WCDSS obtained information from the child's pediatrician who reported the child's immunizations were up to date and the child's height and weight were in the normal range.The child was last seen on 2/10/21 and the doctor did not have any concerns for the parents' care of the child. The child was healthy and not on any medications. It was reported that the parents followed through with appointments and recommendations. The investigation conclusion narrative noted that the

mother had previously received safe sleep education. The mother stated that she normally used the Pack 'N Play to put the child to sleep and it was the first time she had left the child on the bed.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From an injury - external cause
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 reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057511 - Deceased Child, Male, 1 Mons	057512 - Mother, Female, 19 Year(s)	DOA / Fatality	Substantiated
057511 - Deceased Child, Male, 1 Mons	057512 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated
057511 - Deceased Child, Male, 1 Mons	057512 - Mother, Female, 19 Year(s)	Internal Injuries	Unsubstantiated
057511 - Deceased Child, Male, 1 Mons	057513 - Father, Male, 19 Year(s)	DOA / Fatality	Substantiated
057511 - Deceased Child, Male, 1 Mons	057513 - Father, Male, 19 Year(s)	Inadequate Guardianship	Substantiated
057511 - Deceased Child, Male, 1 Mons	057513 - Father, Male, 19 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:
WCDSS documented efforts to interview the SF; however, he refused to be interviewed. The record did not reflect efforts to speak with EMS and hospital staff.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS made a referral to a victim's assistance program for bereavement counseling and funeral assistance. The service provider made outreaches to the family; however, the family did not return the phone calls.

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

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