Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-18-061

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

Issue Date: Mar 21, 2019

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 10/28/2018
Initial Date OCFS Notified: 10/28/2018

Presenting Information

The SCR report alleged on the morning of 10/28/18 at approximately 7AM, the mother checked on the child (age 5 months). At that time, the mother observed the child to be a bluish color and not breathing. The mother called 911 and when EMS arrived, they administered CPR on the child. While at the hospital, the child went into cardiac arrest and soon after was pronounced dead.

Executive Summary

On 10/28/18, Westchester County Department of Social Services (WCDSS) received a report from the SCR about the death of a 5-month-old child (SC) that occurred on the same date. The child resided with her mother and there were no surviving siblings. The biological father of the SC had only just become aware of the existence of the SC two weeks prior to her death and saw her one time and paternity had not been established.

Through interviews with the mother, it was learned on 10/28/18 between 6AM and 7AM the mother woke up and checked on the SC who appeared fine. The child was on her back in her co-sleeper on top of a changing pad, which was being used as a mattress and was placed in the mother's bed. The mother went into the kitchen to prepare formula for the SC and left the SC lying on her back on the bed in the process. When the mother returned to the SC at approximately 7:15AM, the SC was unresponsive and on her belly with her head facing to the side. The mother immediately had her neighbor call 911 due to her not having a phone. The neighbor began CPR at the direction of the 911 operator and continued until Emergency Medical Services responded and took over efforts. The SC was brought via ambulance to Phelps Memorial Hospital, but never recovered and was pronounced deceased at 7:58AM on 10/28/18.

WCDSS made extensive efforts to interview first responders and diligently documented all casework activity. WCDSS spoke with familial collateral contacts and medical personnel. Due to the mother’s refusal to sign releases, pertinent medical records were not obtained. WCDSS sought legal advice following the mother’s refusal to sign releases; the ADA’s office was unable to subpoena collateral documentation.

WCDSS indicated the allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the SC. WCDSS conducted a joint investigation with Ossining Police Department. Ossining Police Department found no criminality in the SC’s death and no criminal charges were filed. During the investigation it was learned that the mother used a baby changing pad as a mattress in the co-sleeper. The label on said changing pad stated, “not to be used for a baby to sleep on and only should be used for changing a baby. Babies have suffocated while sleeping on changing pads. Changing pads are not designed for safe sleeping. Never allow babies to sleep on changing pads.” WCDSS determined the mother failed to exercise a minimum degree of care as an aggravating factor was present and the sleeping area created an unsafe condition.

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:
WCDSS determined that there was sufficient evidence to indicate the allegations of Inadequate Guardianship and DOA/Fatality due to the mother using a baby changing pad as a co-bedding mattress, which contributed to the child's death.

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 appropriately closed the case after arranging community supports for the mother. Due to there being no surviving siblings and no other children residing in the home, there was not a need for ongoing preventive services.

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: 10/28/2018 **Time of Death:** 07:58 AM

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? 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 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	Female	5 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)

LDSS Response

WCDSS received the report from the SCR on 10/28/18 and coordinated efforts with LE, reviewed the CPS history, and notified the DA's office about the death. Throughout the investigation, collateral contacts were made with family members, first responders, and medical professionals. There were no surviving siblings.

On 10/28/18, WCDSS interviewed the mother at a friend's home where she was temporarily staying. The mother stated the day leading up to the SC's death was "typical." She said the child had been teething the night leading up to her death and she gave her .2 ounces of children's Tylenol when placed to sleep. The record does not reflect whether the doctor recommended giving the medication to the SC, but the mother said she gave it to the child on an "as needed" basis. The amount given to the SC was within the recommended dosage on the label. She said she placed the child to bed on her back strapped onto the changing pad in her co-sleeper, which was placed on top of her own bed. The mother said she woke between 6AM and 7AM and checked in on the SC. She said the SC appeared "fine" at that time and was "babbling." The mother then went to make formula for the SC and returned to wake the child for their morning walk at around 7:15AM. At that time, the mother found the SC had rolled over onto her stomach with her head to the side. The SC was unresponsive and the mother recalled her arms had turned purple. The mother found her neighbor who called 911 and began CPR at the direction of the operator and continued efforts until EMS arrived. The SC was transported to Phelps Memorial Hospital where she was pronounced deceased at 7:58AM. The mother denied substance abuse and denied a history of substance abuse. The mother reported that several days prior to the child's death, she saw her attempt to roll over, but was unsuccessful.

WCDSS spoke with the alleged biological father of the SC. The father reported he only found out about the existence of the child two weeks prior and paternity had not been established. The father said he met the child one time. The father did not have any caretaking responsibilities for the SC in the time she was alive.

WCDSS interviewed the neighbor, family members, and a friend who the mother stayed with immediately following the SC's death. All expressed no concerns for the mother's care of the child. All denied concerns that the mother had a history of substance abuse.

WCDSS conducted a joint investigation with Ossining Police Department. Ossining Police Department determined the death was not criminal and closed their investigation. LE notified WCDSS that the changing pad taken from the co-sleeper

had a warning tag attached that advised against infant sleeping.

WCDSS was unable to obtain pertinent medical records regarding the child as the mother refused to sign releases of information. WCDSS was diligent in seeking legal advice upon the mother's refusal and it was determined there was not enough evidence to subpoena records from the hospital and pediatrician.

WCDSS indicated the allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the SC. During consultation and discussions with law enforcement and forensic child abuse pediatrician, it was learned that the changing pad that the mother used in the co-sleeper had a strap to be used while changing a baby. It was learned that the mother used the strap to keep the SC from rolling out of the co-sleeper. At the time of this writing, the final autopsy report had not been received from the ME's office. WCDSS completed timely and adequate safety and risk assessments though they were deemed unnecessary as there were no surviving siblings. WCDSS provided the mother with bereavement and funeral assistance information. Their work exceeded regulatory requirements as they found the mother a grief counselor specific to her nationality. It is unknown if the mother followed through with the resources provided to her.

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048886 - Deceased Child, Female, 5 Month(s)	048885 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
048886 - Deceased Child, Female, 5 Month(s)	048885 - Mother, Female, 35 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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 made diligent efforts to contact collaterals, but the mother refused to sign any releases of information for medical records. Legal was consulted as a result and it was determined that medical records could not be received.

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:
WCDSS provided information for bereavement counseling and mental health services to the SM. WCDSS provided information to the SM on a therapist with the same nationality as the mother in order to help with any cultural barriers. WCDSS provided several resources to assist with funeral expenses and found a program to bring the cost down significantly.

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 surviving siblings or other children in the household.

History Prior to the Fatality

Child Information

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/21/2018	Deceased Child, Female, 5 Months	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The report alleged that on 5/17/18, SM gave birth to the SC. The SM was not bonding well with the infant and not spending time with the SC. There was concern for SM's ability to care for the SC. The SM did not have any supports and did not have a pediatrician for the SC. There were numerous animals in the home that posed a safety risk for the SC.

Report Determination: Unfounded | **Date of Determination:** 07/18/2018

Basis for Determination:
WCDSS made numerous home visits to assess the safety of the SC. The home was deemed safe on all occasions and the two cats in the home were kept away from the SC with the installation of "baby gates", which the SM reported kept the cats away from the SC. SM had the support of family, who came to stay with her upon the arrival of the SC. WCDSS received appropriate collateral contact from SC's pediatrician, which concluded that the SC was up to date with immunizations and there were no concerns for her health. WCDSS unfounded and closed their case on 7/18/18 due to lack of some credible evidence.

OCFS Review Results:
WCDSS made appropriate collateral contacts and thoroughly documented in the case record. WCDSS completed a timely and accurate safety assessment and CPS history check. WCDSS did not review safe sleep with the SM despite the new infant in the home. WCDSS did not gather information on the SC's biological father, add him to the case, or notify him of the existence of a report.

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

Issue:
Failure to provide safe sleep education/information

Summary:
Though they were in the home and documented sleep provisions for the SC, WCDSS did not have a conversation surrounding safe sleep education/information at any point during the investigation despite SM having a newborn.

Legal Reference:
13-OCFS-ADM-02

Action:
WCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

PIP Requirement:
WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Issue:
Failure to provide notice of report

Summary:
WCDSS did not provide a Notice of Existence letter to the parents in a timely matter. The father was not provided with an NOE and WCDSS did not document any attempts to contact him regarding the report. WCDSS did not send a Notice of Existence to the SM until 7/18/2018, more than 60 days after the start of the investigation.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:

WCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

PIP Requirement:

WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

[redacted]

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

There was 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