Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-037

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

Issue Date: Dec 31, 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		

Case Information

Report Type: Child Deceased
Age: 1 month(s)

Jurisdiction: Westchester
Gender: Male

Date of Death: 07/17/2019
Initial Date OCFS Notified: 07/17/2019

Presenting Information

An SCR report alleged on 7/17/19, the father left the home to pick up the five-year-old sibling from daycare leaving the one-month-old napping on the couch unsupervised. As a result, the infant fell off the couch and onto the floor. The father returned to the home at an unknown time. The father discovered the infant face-down on the floor and he was not breathing. At 6:00 PM, the father called authorities to seek medical treatment. The fire department and law enforcement arrived on scene and performed CPR on the infant. The mother was asleep in the bedroom upstairs prior to the father leaving the home. It was unknown if the mother was aware that the father was leaving the home or that the infant was left unsupervised.

Executive Summary

On 7/17/19, the Westchester County Department of Social Services (WCDSS) received an SCR report regarding the death of the one-month-old male infant. The infant resided with the mother, father and two siblings, ages nine and five. The nine-year-old sibling was visiting relatives in Japan for the summer.

WCDSS conducted a joint investigation with law enforcement immediately upon receipt of the report. It was learned on 7/17/19, the father and five-year-old sibling arrived home around 6:00 PM and they could not find the infant. They located the mother upstairs in the bedroom and she said she placed the infant on the couch for a nap, then she went upstairs to take a nap. The father and sibling found the infant face-down and unresponsive on top of blankets on the living room floor next to the couch. The father ran outside and asked someone to call 911. First responders arrived and performed CPR for a short time before determining the infant was deceased at 6:13 PM.

An autopsy was performed, and the medical examiner determined the cause of death was “Asphyxia due to unsafe sleeping on a couch of a 1-month-old infant found next to couch on floor face-down on soft bedding” and the manner of death was “Accident: Fell in face-down position.” The medical examiner reported the infant had no visible injuries, except for what appeared to be signs of suffocation. The law enforcement investigation remained open with no charges filed at the time this report was written.

Law enforcement observed the home to be in disarray and there was no crib or bassinet. The parents reported to WCDSS that they were aware of safe sleep guidelines, although they did not purchase a crib, and the infant slept on the couch in the living room. The mother was recuperating from a medical procedure following the birth of the infant, and she was caring for the infant alone during the day while the father was at work and the five-year-old sibling was at daycare.

WCDSS initiated a safety plan on 7/17/19, that relatives would supervise the parents’ contact with the siblings. An Article 10 Neglect Petition was filed in Family Court on 8/2/19 and a temporary order of protection was issued on 8/7/19 that barred the parents from unsupervised contact with the siblings. The order of protection was later modified to state that the father could supervise the mother’s contact with the siblings. The parents completed substance abuse evaluations, and both tested positive for alcohol and no treatment was recommended.

WCDSS thoroughly investigated the incident and contacted all necessary collaterals, including law enforcement, EMS, the DA’s office, the medical examiner, CPS in Japan, hospital staff, and multiple relatives.

WCDSS appropriately substantiated the allegations against the parents. They failed to provide the infant with a safe

sleeping environment or adequate care and supervision. The mother left the infant on a couch unattended for several hours while she napped on the second floor of the home. During that time, the infant fell off the couch and asphyxiated on soft bedding on the floor. The parents were aware of the mother's limitations due to her medical condition and they failed to make a safe plan for the infant's care. WCDSS referred the family for bereavement services and opened the case for ongoing CPS services.

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?** 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:
The case was appropriately indicated and opened for ongoing CPS services.

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

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:
Casework activity was commensurate with best casework practice.

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: 07/17/2019 **Time of Death:** 06:13 PM

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: 06:00 PM
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? No - but needed
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)

LDSS Response

WCDSS displayed best casework practice in their investigation of the infant's death. They searched SCR history, contacted the source of the report, and worked collaboratively with law enforcement. WCDSS diligently contacted CPS in Japan to conduct a safety assessment of the siblings while the family was there for the funeral services. WCDSS referred the family for the appropriate services and filed a petition in Family Court to obtain the necessary court ordered services.

Through interviews with the parents, it was learned that the infant was healthy and up-to-date with well-child visits. The mother had medical complications from child birth that required surgery and she was hospitalized until 7/1/19. Following her discharge from the hospital, the mother's activities were restricted and the father slept in the living room with the infant

and provided him care at night. The infant slept on the couch on top of blankets and the father slept on the floor next to the couch with blankets and pillows. The parents reported they had a toddler bed for the infant that they planned to use when he turned one, and they did not want to purchase a crib for just one year.

The parents reported on 7/17/19 at 7:00 AM, the father fed the infant a bottle then woke up the mother. The father dropped the five-year-old sibling off at daycare and he went to work. The mother said she fed the infant a bottle at 10:00 AM. She later sent a picture of the baby to the father and he appeared fine at that time. The mother provided conflicting information about what time she gave the infant a second bottle. After his second bottle, the mother placed the infant on his back, on top of several baby blankets on the couch. The mother covered the infant with a blanket up to his stomach and she went upstairs to take a nap. The mother woke up at 5:30 PM and she did not hear the infant, so she thought he was still sleeping. She was awake in the bedroom when the father and five-year-old sibling arrived home at 6:00 PM. They did not see the infant downstairs, so they went upstairs and asked the mother where he was. The father and five-year-old sibling went back downstairs and located the infant face-down on top of blankets on the floor next to the couch and the infant was not moving. The father could not find his phone, so he ran outside and asked someone to call 911.

WCDSS attempted to interview the five-year-old sibling and they were unsuccessful. Multiple family members were spoken to and were assessed to be safe resources for the siblings. The nine-year-old sibling was assessed to be safe by CPS in Japan.

Official Manner and Cause of Death

Official Manner: Accident
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
050801 - Deceased Child, Male, 1 Mons	050806 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
050801 - Deceased Child, Male, 1 Mons	050802 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
050801 - Deceased Child, Male, 1 Mons	050802 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
050801 - Deceased Child, Male, 1 Mons	050802 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated
050801 - Deceased Child, Male, 1 Mons	050806 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
050801 - Deceased Child, Male, 1 Mons	050806 - Father, Male, 34 Year(s)	Lack of Supervision	Substantiated

050807 - Sibling, Female, 5 Year(s)	050802 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
050807 - Sibling, Female, 5 Year(s)	050806 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
052341 - Sibling, Male, 9 Year(s)	050806 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
052341 - Sibling, Male, 9 Year(s)	050802 - Mother, Female, 33 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?	☐	☒	☐	☐
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:

During the investigation, WCDSS was unsuccessful in obtaining releases from the parents to speak to the children's pediatrician. Attempts were made to interview the siblings and were unsuccessful.

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	☒	☐	☐	☐

Explain:
Risk was adequately assessed and an Article 10 Neglect Petition was filed to obtain the required services.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

08/02/2019	There was not a fact finding	There was not a disposition
Respondent:	050802 Mother Female 33 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against the parents and was pending in Family Court at the time this report was written.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/02/2019	There was not a fact finding	There was not a disposition
Respondent:	050806 Father Male 34 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against the parents and was pending in Family Court at the time this report was written.	

Have any Orders of Protection been issued? Yes	
From: 08/07/2019	**To:** Unknown
Explain: An order of protection was issued against the parents barring them from unsupervised contact with the siblings. The order was modified on 11/14/19, to allow the father to supervise the mother's contact with the children.	

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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The siblings were referred for bereavement services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were referred for bereavement services and a substance abuse evaluation.

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 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 New York State.

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