Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-20-048

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

Issue Date: Apr 26, 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: 5 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 11/12/2020
Initial Date OCFS Notified: 11/13/2020

Presenting Information

On 11/13/20, Westchester County Department of Social Services (WCDSS) received an SCR report that stated shortly before 11:14PM on 11/12/20, the father left the subject child alone on a bed in an unspecified room, in order to go downstairs to help the mother bring in groceries. It was unknown if there were any items on the bed with the child. When the father returned, he observed the child lying face-down on the bed. The father called 911 and law enforcement and emergency medical services responded. Cardiopulmonary resuscitation was administered at the scene for an unknown amount of time. The child was transported to the hospital and pronounced deceased. The child was otherwise healthy and the father had no explanation for his death. The mother and sibling had an unknown role.

Executive Summary

On 11/13/20, the Westchester County Department of Social Services (WCDSS) received an SCR report regarding the death of the 5-month-old male child that occurred on 11/12/20. At the time of the child's death, he resided with his mother and 3-year-old sibling. The father did not reside in the home, but frequented the residence.

WCDSS conducted a joint investigation with law enforcement and they learned that on 11/12/20, the mother and father were home with the subject child and sibling. The mother bottle fed the subject child and then left the home to retrieve more formula from the daycare provider. While out, the mother also went grocery shopping. After the mother left the home, the father placed the child on his back on the parents' full size bed. The father surrounded the child with pillows and placed a body pillow at the top of the bed to prevent the child from falling through the crevice. The father stayed in the bed with the child until the child fell asleep, and then went into another room to watch television. The mother returned home approximately one hour later and the father went downstairs to help bring the groceries in. When the father returned to the bedroom to check on the child, he observed the child face-down with a puddle of blood and vomit under his face. The child was unresponsive and the father yelled for the mother to call 911. The father brought the child to a counter top and began CPR. First responders arrived and took over resuscitation efforts. The child was transported to the hospital where he was pronounced deceased at 11:51PM.

The family relocated after the fatal incident due to detection of carbon monoxide in their building. The parents reported that prior to the fatality, they had filed complaints to building management regarding environmental chemicals in the home, and the family had been assessed medically due to this. The parents believed that the subject child may have been exposed to carbon monoxide and questioned if it contributed to his death. The surviving sibling's safety was assessed through professional and familial contacts during the investigation and there were no concerns for her care.

WCDSS requested a copy of the autopsy report; however, it had not been completed at the time this report was written. The Medical Examiner stated that due to concerns of possible exposure to carbon monoxide, testing was completed to determine if this contributed to the death, and the tests returned negative. The Medical Examiner stated while there was not yet a formal cause of death, it was most likely caused by the child aspirating vomit into his lungs. At the time the case was closed, no criminal charges had been filed related to the subject child's death or against the property owners in relation to the carbon monoxide. The criminal investigation remained open pending the final autopsy report.

WCDSS unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother and father. WCDSS determined that there was no information gathered during the investigation which showed causation between the

parent's action and the death of the child. The family was provided with grief counseling and a referral to Victim's Assistance Services. The CPS investigation was closed on 1/12/21.

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

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:
There was detailed supervisory consultation documented in the case record. The sibling's safety was assessed throughout the investigation and it was determined there was no further need for child welfare involvement.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	It was not documented that all risk factors were explored with the parents.
Legal Reference:	18 NYCRR 432.2(d)
Action:	For child abuse or maltreatment reports that are assigned to the investigative track, risk assessment must be employed by the child protective service when key case decisions are made concerning a child named in the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/12/2020 **Time of Death:** 11:51 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: 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? 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	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

WCDSS investigated the incident by searching SCR history and speaking to the source of the report, first responders, the Assistant District Attorney and the Medical Examiner. On the day of the fatality, the SM and SF were interviewed and the SS was assessed to be safe with her parents.

During interviews with the SM and SF, they reported the night of the fatality they were home with the child and sibling. The SM fed the child a bottle at about 7:30PM. The SM stated she needed more formula and had some at the daycare provider, so she left the home to go get it. While out, the SM called the SF and stated she was going to get groceries as

well. Shortly after the SM left the home, the SF placed the child on the parents' full size bed on his back. The SF placed a ring of pillows in a semi-circle around the middle of the bed, where the child was placed. In addition, the SF placed the SM's pregnancy pillow by the headboard separation, in order to prevent any access by the child. The SF laid in bed and watched television with the child. After the child fell asleep, the SF left the room and went to watch television in the other room. The SF stated that the child was a light sleeper and he did not want to wake him. The SF reported that he did not check on the child prior to the SM coming home, because he wanted his son to sleep and did not believe there was an immediate need to do so. The SM arrived home and called the SF at 10:50PM and informed him that she was at home. The SF reported to the SM that the children were asleep. The SF went downstairs and brought up 3 bags of groceries. On arrival back in the apartment, the SF checked on the child. The SF reported that upon looking into the bedroom, he observed the child face-down, with a puddle of milk and blood under his face. The SF reported that he immediately picked up the child and he appeared to be blueish about the lips. The SF brought the child to the kitchen in order to lay him flat on the raised island counter and initiated CPR. The SF yelled for the SM to call 911, which the SM stated she had promptly done. The SM ran downstairs in order to bring the police upstairs. The parents reported that law enforcement arrived quickly and went upstairs. Law enforcement immediately took over CPR. The SF noted that he observed fluid come from the child's mouth. Emergency Medical Services arrived and transported the child to the hospital. The sibling was reported to be sleeping throughout the incident.

It was not documented that the parents were questioned regarding drug and alcohol use or about their knowledge of safe sleep practices. Although the child was reported to have been placed in an unsafe sleep environment due to the sleep surface and pillows, the record did not reflect this was addressed with the parents. WCDSS documented that there was a crib and bassinet in the home.WCDSS completed several home visits during the investigation, where they observed the sibling to be safe with the parents and to have sufficient provisions and age appropriate sleeping arrangements. It was not documented that the parents appeared to be impaired during casework contacts.

WCDSS obtained information from collaterals, including the daycare, pediatrician and school regarding the SC and SS. The SC was up to date on routine medical appointments and there was no concern for his health or the health of the SS. The daycare provider reported she had provided care for the SC since he was a few weeks old and that he was a happy and healthy baby and there was no concern for his care. The sibling's school reported she appeared well taken care of and they had no concern for her care. The medical examiner reported the subject child appeared clean, well nourished, with no signs of trauma, and that he did not think the parents did anything wrong.

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The record reflected that the fatality was reviewed by Westchester County's CFRT on 11/30/20.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

056669 - Deceased Child, Male, 5 Mons	056671 - Father, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
056669 - Deceased Child, Male, 5 Mons	056671 - Father, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
056669 - Deceased Child, Male, 5 Mons	056670 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
056669 - Deceased Child, Male, 5 Mons	056670 - Mother, Female, 29 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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:
It was not documented that the interviews with the parents contained questions regarding all risk factors, including domestic violence and drug or alcohol use; therefore, it was unclear if they made appropriate referrals for 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? 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:
As a result of the fatality, the parents were offered grief counseling and provided with a referral to a Victim's Assistance program. The mother was engaged in mental health counseling prior to the fatality.

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 parents were offered age appropriate grief counseling on behalf of the sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered grief counseling and a referral to a Victim's Assistance program.

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