Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-030

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

Issue Date: Nov 25, 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: 06/14/2019
Initial Date OCFS Notified: 06/17/2019

Presenting Information

On 6/14/19, an SCR report was received that alleged on 6/13/19, the mother and father fell asleep with the infant in bed with them. During the night, the father rolled over onto the infant and suffocated him. Early in the morning on 6/14/19, the infant was found blue in color and deceased. Additional SCR reports were received on 6/21/19 and 8/21/19, that alleged the father fell asleep with the infant on his chest and rolled over onto the infant, causing his death.

Executive Summary

Westchester County Department of Social Services (WCDSS) received SCR reports regarding the infant's death on 6/14/19, 6/21/19 and 8/21/19. At the time of the infant's death, he resided with his mother and maternal grandparents in Putnam County. The mother and the infant were visiting the father's home in Westchester County for a few days, and that was where the fatal incident occurred. The father resided with the paternal grandparents and a paternal uncle. The mother and father had no other children and they had no previous SCR history.

WCDSS collaborated with the New York State Police and Putnam County Department of Social Services (PCDSS) to conduct a thorough investigation. It was learned on 6/14/19, around 2:30 AM, the father took the infant out of his bassinet and fed him while lying in bed. The mother woke up at 4:00 AM and saw the father lying in bed watching television, with the infant sleeping on his chest. She went upstairs to get ready to leave for her treatment program and returned to the bedroom about 4:30 AM. Upon entering the bedroom, the mother discovered that the father had fallen asleep and rolled onto his side. She searched for the infant and then noticed the infant's leg sticking out from underneath the father. She yelled and pushed the father off the infant. The mother laid the infant on the floor and called 911. She followed instructions for CPR until EMTs arrived and took over. The infant was transported to the hospital, where he was pronounced deceased. The paternal grandparents were sleeping at the time of the incident and the uncle was not home.

An autopsy was performed, and the final report had not been received at the time this report was written. WCDSS spoke to the medical examiner, who reported the infant's death was caused by the father's overlay. He said there were no other physical signs of trauma or mistreatment. The law enforcement investigation remained open and no criminal charges had been filed at the time this report was written.

WCDSS contacted necessary collaterals and interviewed all family members. It was learned that both parents had a history of substance abuse. They were enrolled in an opioid maintenance program and attended a counseling center daily. Both parents denied being under the influence of drugs at the time of the incident. Law enforcement performed drug tests on 6/14/19, and both parents tested positive for opiates and did not have a prescription. Law enforcement was conducting further testing to determine the level of drugs present and to establish a timeline when it was ingested. WCDSS further learned that there had been a recent incident where the father struck the mother while she was holding the infant, causing the infant to fall onto the bed. After the incident, the mother took the infant and left the father's home.

WCDSS accurately substantiated the allegations of Parent's Drug/Alcohol Misuse, Inadequate Guardianship and DOA/Fatality against both parents in all three investigations. Both parents tested positive for opiates on the day of the incident and they were the sole caretakers for the infant. The father engaged in physical violence towards the mother and the mother returned to the father's home with the infant, placing the child at risk of harm. The father was aware of the dangers of co-sleeping and fell asleep with the infant on his chest, resulting in the father rolling over on the infant, and causing the infant's death. The mother was aware the father had been up throughout the night watching television. She

was aware of the dangers of co-sleeping and did not intervene and place the infant back in his bassinet prior to leaving the infant unattended with the father.

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:
The decision to indicate and close the case was appropriate.

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:
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: 06/14/2019 **Time of Death:** Unknown

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? 30 Minutes
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	Grandparent	No Role	Female	60 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	60 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	24 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	34 Year(s)
Other Household 1	Grandparent	No Role	Male	70 Year(s)
Other Household 1	Grandparent	No Role	Female	60 Year(s)

LDSS Response

WCDSS initiated their investigation upon receipt of the SCR report on 6/14/19. They contacted the source, searched SCR history, conducted a home visit to the father's home and spoke to law enforcement, the parents and grandparents.

Through interviews with the mother and father it was learned the infant was born prematurely at 35 weeks gestation and his weight was monitored by his pediatrician. The parents reported they were aware of safe sleep guidelines and said they always placed the infant to sleep on his back in the bassinet, with no other items, and they never co-slept with the infant.

The parents reported on 6/13/19 at 9:00 PM, the mother placed the infant to sleep in his bassinet. The mother then went to sleep, and the father laid in bed and watched television. The mother awoke and fed the infant at 1:00 AM and then placed him back to sleep in his bassinet. The father fed the infant at 2:30 AM, then continued to watch television with the infant lying on his chest. The mother awoke at 4:00 AM and observed the infant to be sleeping on the father's chest and the father was awake and watching television. The mother asked the father if he was sleepy and the father replied he was fine.

The mother went upstairs to get ready to leave for her treatment program. She returned to the bedroom at 4:30 AM and found the infant underneath the father. She picked up the infant, who was limp, and laid him down on the floor. She performed CPR while on the phone with the 911 dispatcher. The father stood outside the bedroom yelling “what have I done” and crying.

On 6/14/19, WCDSS observed the father’s home to contain no safety hazards. There was a bassinet in the father’s bedroom and the full-sized bed where the incident took place was observed. Law enforcement conducted a re-enactment with the mother, which was consistent with the father rolling over onto the infant. The paternal grandparents reported they were upstairs sleeping, and the uncle said he was not home at the time of the incident. The paternal grandparents had no concerns for the parents’ care of the infant and they did not believe the parents used drugs on the night of the incident.

On 7/29/19, PCDSS conducted a home visit at the mother’s home and interviewed the maternal grandmother. There were no safety hazards observed and the maternal grandmother had no concerns for the parents' care of the infant.

The parents’ substance abuse treatment provider confirmed the parents were enrolled in and attending a treatment program and they provided the parents with grief support services. WCDSS referred the parents for additional grief support services and the case was appropriately closed as there were no surviving siblings.

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
051961 - Deceased Child, Male, 1 Mons	051963 - Father, Male, 34 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
051961 - Deceased Child, Male, 1 Mons	051963 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
051961 - Deceased Child, Male, 1 Mons	051963 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
051961 - Deceased Child, Male, 1 Mons	051962 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
051961 - Deceased Child, Male, 1 Mons	051962 - Mother, Female, 23 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
051961 - Deceased Child, Male, 1 Mons	051962 - Mother, Female, 23 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?	☒	☐	☐	☐
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?	☐	☒	☐	☐

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:
The parents were referred for grief support services and they continued with substance abuse treatment services.

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? 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