Child Fatality Report

Report Identification Number: SV-21-034

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

Issue Date: Feb 14, 2022

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: 6 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 08/25/2021
Initial Date OCFS Notified: 08/25/2021

Presenting Information

An SCR report alleged on 8/24/21, the mother found the 6-month-old male subject child unresponsive in his crib with vomit on his mouth at 11:15 PM. The child was transported to the hospital where he was pronounced deceased at 12:25 AM on 8/25/21. The parents and the grandparent were caregivers to the child and had access to the child at the time of his death. The adults did not have an explanation for the child's death and therefore were all listed as alleged subjects. Two additional SCR reports were received, one of which named the mother's 14-year-old cousin as a subject, and were consolidated into the initial investigation.

Executive Summary

This fatality report concerns the death of the 6-month-old male subject child that occurred on 8/25/21. A report was made to the SCR the same day regarding concerns the child was found unresponsive while in the care of the parents and grandfather. Two additional reports were made on the same day and the 14-year-old cousin was named an adult alleged subject. The reports were consolidated into the initial investigation. At the time of his death, the child resided with his parents. There were no other children or siblings.

Westchester County Department of Social Services (WCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The family had no known criminal history and no CPS history. The criminal investigation was closed without charges. An autopsy was performed, and the medical examiner listed the cause of death was due to asphyxia of a 6-month-old due to unsafe sleep in an adult bed. The manner of death was accidental.

The parents and grandfather reported the mother was home with the child and her 14-year-old cousin when the mother found the child lifeless after she had placed him face-down on an adult sized bed between pillows. The cousin called 911 while the mother called the father to notify him that the child was unresponsive and not breathing. The father called the grandparents who arrived at the home and the grandfather performed CPR until first responders arrived and took over resuscitation efforts. The child was transported to the hospital where he was pronounced deceased.

WCDSS gathered collateral information from first responders including EMS and law enforcement, and from hospital staff, family members and the pediatrician’s office. The investigation revealed the mother’s recollection regarding how she found the child was inconsistent. In separate recollections, the mother reported the child was face-down on the adult bed, in his crib and she also reported the child was found wedged in between the bed and a wall. Information gathered from the pediatrician’s office noted that the parents were provided with safe sleep education and there were no concerns noted for the child’s care.

WCDSS made diligent attempts to gather contact information for the mother's 14-year-old cousin; however, were unsuccessful in locating or contacting her. The allegations of Inadequate Guardianship and DOA/Fatality against her were unsubstantiated as the 14-year-old minor cousin was inaccurately identified as an adult on an SCR report and she was not found to be a person legally responsible for the child. The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the grandfather. The investigation revealed the grandfather was not a person legally responsible for the child, nor was he present at the time the child was placed to sleep or when the child was discovered unresponsive. The parents were substantiated for Inadequate Guardianship. The parents had a history of co-sleeping with the child in between them in the bed. The father was unsubstantiated for the allegation of DOA/Fatality as he was not home at the time the child was placed to sleep and he did not have any role in the child’s death. The mother was substantiated for

DOA/Fatality as her action of placing the child in an unsafe sleeping environment directly contributed to the death.

WCDSS conducted home visits and met with family members. The interviews with the parents, family members and collateral contacts were thorough and progress notes were entered contemporaneously to their event dates. Required reports were completed timely and accurately and the investigation was closed timely on 10/22/21 after all casework requirements were met.

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:
No Safety Assessments were required as there were no surviving siblings or other children in the household. The decision to 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 case circumstances.

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: 08/25/2021 **Time of Death:** 12:25 AM

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? 2 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **In another room**

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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Male	57 Year(s)
Other Household 1	Other Child - Cousin	Alleged Perpetrator	Female	14 Year(s)

LDSS Response

On 8/25/21, WCDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, WCDSS documented a CPS history check, contacted the source of the initial SCR report, and gathered information from hospital staff and law enforcement. The district attorney and medical examiner's offices were made aware of the death. Two additional SCR reports were received and were consolidated into the initial investigation. WCDSS contacted and gathered information from the sources of those reports.

Law enforcement shared information that the child was placed on the parents' bed after being fed around 8:00 PM. Around 11:00 PM, the mother checked on the child and found the child unresponsive with vomit on his face. The grandfather was performing CPR when EMS arrived, took over resuscitation efforts and transported the child to the hospital. Law enforcement provided information the mother found the child wedged between a gap between the bed and the wall. When the mother picked the child up, he felt heavier than normal and was lifeless. She told the cousin to contact 911 while she contacted the father, who contacted the grandfather. The father reported to law enforcement that he received a call from

the mother saying the child was in a medical crisis, so he asked his parents to go to the home to help.

The grandfather said the mother gave the child milk and put him on the adult bed as he had been crying in the crib. Around 8:00 PM, the mother placed the child face-down on the bed and discovered him face-down in vomit around 11:00 PM. The grandparents went to the home and the grandfather performed CPR until first responders arrived and transported the child to the hospital. The grandparents did not have concerns for the way the mother cared for the child and said she was a good mother.

WCDSS interviewed the parents together and the mother said on 8/24/21, she came home from work around 8:00 PM and tended to the SC, who was being babysat by the cousin. The mother bathed the child around 9:30 PM and placed the child on an adult bed, on his stomach as that is how the child preferred to sleep. The mother placed a pillow on both sides of the child as he was able to roll over. The parents stated the child would regularly sleep on the bed in between them. The mother checked on the child around 11:40 PM, and he was on his stomach with his head to the side. She noticed that he was not breathing or moving, so she picked him up and he was unresponsive. She yelled for the cousin to call 911 and the mother called to notify the father of the situation. The father called the grandfather, who arrived at the home and performed CPR until EMS responded and took over.

WCDSS received hospital records that stated the child arrived at the hospital in cardiac arrest with aspiration in his airway. Resuscitation efforts were continued; however, were discontinued and the child was pronounced deceased.

The medical examiner said the child's vomit contained beans, which were also discovered under a pillow on the adult sized bed; however, the mother had initially reported to first responders that the child was in his crib. Later the mother stated the child was on the adult bed with pillows around him. The medical examiner said the child's head would not have been wedged between the bed and the wall had the child been placed on his back in a crib and further noted the child's death was due to the unsafe sleeping environment.

Although the mother provided inconsistent accounts of the fatal incident, WCDSS appropriately determined their investigation as the mother placed the child in an unsafe sleeping environment and the child died as a result of the mother's actions. The parents were offered mental health services in response to the death. The father was engaged in counseling through his employer. It remained unknown if the mother utilized the service.

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 referred to an OCFS approved Child Fatality Review Team?Yes
Comments: The death was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

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

059411 - Deceased Child, Male, 6 Mons	059412 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
059411 - Deceased Child, Male, 6 Mons	059412 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
059411 - Deceased Child, Male, 6 Mons	059414 - Other Child - Cousin, Female, 14 Year(s)	DOA / Fatality	Unsubstantiated
059411 - Deceased Child, Male, 6 Mons	059414 - Other Child - Cousin, Female, 14 Year(s)	Inadequate Guardianship	Unsubstantiated
059411 - Deceased Child, Male, 6 Mons	059415 - Grandparent, Male, 57 Year(s)	DOA / Fatality	Unsubstantiated
059411 - Deceased Child, Male, 6 Mons	059415 - Grandparent, Male, 57 Year(s)	Inadequate Guardianship	Unsubstantiated
059411 - Deceased Child, Male, 6 Mons	059413 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
059411 - Deceased Child, Male, 6 Mons	059413 - Father, Male, 23 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

Additional information:

Although diligent attempts were made to obtain contact information for the mother's minor cousin, WCDSS was unable to locate the cousin to interview her.

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 offered mental health counseling. The father was receiving counseling through his employer. It remained unknown if the mother utilized the service.

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 was no CPS investigative 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.

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