Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-18-065

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

Issue Date: Apr 12, 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: 4 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 11/15/2018
Initial Date OCFS Notified: 11/15/2018

Presenting Information

An SCR report was received on 11/15/18, which stated after the mother fed the 4-month-old infant between 1:00-2:00AM, she placed him in his portable crib. At about 6:30AM the father found the infant blue and lifeless in the portable crib. The parents called 911 and first responders arrived at the home. The infant was taken to the ER, where his death was declared. The infant was in the care of the mother and father at the time of the incident, and therefore they were both considered subjects.

Executive Summary

This report concerns the death of the 4-month-old male infant. Westchester County Department of Social Services (WCDSS) received a report regarding the fatality on 11/15/18, the date of the infant's death. He was an otherwise healthy child and his sudden death was considered suspicious.

In the early morning hours of 11/15/18, the mother fed the infant and placed him in a portable crib. The portable crib had an extra mattress in it that was not an exact fit for the bottom of the crib, so the mother rolled a blanket to fill the gap. The mother went back to sleep. The father woke later that morning and found the infant lying unresponsive in the portable crib. The infant was lying on his side, with his face wedged in the gap between the mattress and netting on the exterior of the portable crib. The father woke the mother and performed CPR while 911 was called. EMS responded and transported the infant to the ER. The infant was unable to be resuscitated.

The ME performed an autopsy and the final report had not yet been received by WCDSS at the time of this writing.

The LE investigation did not lead to any evidence of a crime and no charges were pursued.

WCDSS made several home visits throughout the investigation and found the 2yo surviving sibling to be happy and bonded with his parents. WCDSS spoke with the pediatrician and early intervention service provider for the sibling. The child was reportedly making progress in services and the pediatrician reported no concerns regarding the care the parents provided.

WCDSS substantiated the allegations of inadequate guardianship and DOA/Fatality against the mother and father, based on the facts gathered in their investigation. The sleeping environment where the child slept was unsafe, despite the parents' knowledge of what constitutes safe sleep for infants. The position in which the infant was found by the father indicated his breathing was obstructed, and re-enactment photographs provided by LE also supported that conclusion. WCDSS appropriately concluded that the parents failed to provide a minimum degree of care and this led to the death of the infant. WCDSS found no evidence to substantiate the allegation of inadequate guardianship against the parents regarding the surviving sibling.

WCDSS referred the family for Victims Assistance Services and the parents accepted the referral. The parents were also referred for and actively participating in bereavement counseling. The mother had briefly participated in an online support group, in addition to a support group at the White Plains Hospital. The parents declined any further services and had the support of family and friends in the community.

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:
Information gathered supported the determination made by WCDSS in the investigation.

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 gathered enough information during their investigation to make a determination of the allegations, and it was appropriate to conclude the investigation.

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: 11/15/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Westchester

Child Fatality Report

Was 911 or local emergency number called? Yes
Time of Call: 06:35 AM
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? 5 Hours
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

On 11/15/18, WCDSS received a report regarding the death of the infant. WCDSS began their investigation within 24 hours and coordinated their efforts with LE. WCDSS contacted the source of the report, conducted a CPS history search for the family and notified the DA. An immediate home visit was made to the infant's home and the safety of the surviving sibling was assessed. The parents were at the hospital and WCDSS met with the maternal grandmother and the sibling; he was assessed to be safe and free of any visible injury. WCDSS learned the grandmother drove to the home after receiving a phone call from the father to notify her of the incident. She did not express any concerns regarding the parents' care of either child.

WCDSS spoke with the mother and father at a subsequent home visit on 11/16/18. WCDSS learned that on 11/14/18 at around 8:30PM, the mother placed the infant to sleep in his bassinet. The infant woke at 1:30AM on 11/15/18 and the mother fed him and then placed him on his stomach in a portable crib. The portable crib was in the dining room of the home and the bassinet was in the parents bedroom. The mother explained she had noticed the infant moving a lot in his sleep and thought he was outgrowing the bassinet. The mother stated she placed a small mattress in the portable crib for the purpose of giving the infant comfort. The smaller mattress did not come with the portable crib. The mattress was not an exact fit for the space at the bottom of the crib, so the mother placed a rolled blanket in the space left between the mattress

and the structure. The father told WCDSS he woke at around 6:30AM on 11/15/18 and found the infant lying on his side, with his face pressed against the mattress. He picked up the infant and took him to the mother in the bedroom, where he then began CPR while the mother called 911. The parents reported the infant was cool to the touch and he was pale in color. The paramedics arrived and transported the infant to the hospital. The mother went with the ambulance and the father stayed at the home with the surviving sibling until the grandmother arrived.

WCDSS documented completion of a Sudden Unexplained Infant Death reporting form, based on their interview with the parents. They learned the infant had an infant sized blanket in the portable crib, covering his lower body. The mother and father denied any alcohol or drug use in the home and both acknowledged receiving safe sleep education.

The parents reported the infant had last been to the pediatrician on 11/9/18 for a routine exam and vaccinations. The infant was fussy following the medical appointment and had a fever due to his immunizations. The parents told WCDSS they had been concerned about a "rattling noise" in the infants chest since birth and did address the concern at the 11/9/18 appointment. The pediatrician records documented the mother's expressed concerns and noted giving her a referral for a specialist. The pediatrician had no concerns for the care of health of the infant and stated he was a healthy child.

WCDSS reviewed LE reports and photos taken of the home. The reports were consistent with the accounts provided by the parents to WCDSS.

WCDSS learned the surviving sibling received Early Intervention services. The providers were interviewed by WCDSS and expressed no concerns regarding the care the parents provided to the infant or sibling.

The parents had support from their families and their church after the death of the infant. WCDSS offered referrals for appropriate services and the family was seeking services as needed.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical 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
049521 - Deceased Child, Male, 4 Mons	049525 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
049521 - Deceased Child, Male, 4 Mons	049524 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
049521 - Deceased Child, Male, 4 Mons	049524 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
049521 - Deceased Child, Male, 4 Mons	049525 - Father, Male, 35 Year(s)	DOA / Fatality	Substantiated

049523 - Sibling, Male, 2 Year(s)	049524 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
049523 - Sibling, Male, 2 Year(s)	049525 - Father, Male, 35 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?	☒	☐	☐	☐

Additional information:

WCDSS made several attempts to contact the source of the report, including leaving messages requesting a return call. The source never returned WCDSS phone calls, but did provide written information to WCDSS.

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:
Although the final risk rating was very high due to the death of the infant, and the failure of the parents to provide a minimum degree of care in regard to the sleep environment, the surviving sibling was found to be appropriately cared for. The sibling received Early Intervention services before the infant's passing, and these services continued at the investigation conclusion.

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:
WCDSS encouraged the parents to continue to use their family members as a source of support throughout their grieving period.

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 service needs identified for the surviving sibling as the result of the fatality. The sibling was 2 years old at the time of the infant's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS referred the parents to Victims Assistance Services and bereavement counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

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