Child Fatality Report

Report Identification Number: SV-21-055

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

Issue Date: Apr 29, 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: 9 year(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 12/19/2021
Initial Date OCFS Notified: 12/19/2021

Presenting Information

On 12/19/2021, two SCR reports were received alleging that between 11:00 and 11:30 AM the 9-year-old SC was found on the living room couch unresponsive and not breathing. The SC was found by the SF and adult brother (OA) who attempted CPR and called 911. Emergency personnel responded to the home, continued CPR, and transported the SC to the hospital, arriving at 12:23 PM. Life saving efforts were continued, however the SC was pronounced dead sometime prior to 1:30 PM. The SC was otherwise healthy and the SF and SM had no explanation for the SC's death. The roles of the OA and the 8-year-old, 6-year-old, and 1-month-old SSs were unknown.

Executive Summary

This report concerns the death of a 9-year-old male subject child that occurred on 12/19/2021. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's father and mother. Westchester County Department of Social Services (WCDSS) received the report and investigated the child's death. An autopsy was performed; however, the final report had not yet been issued at the time of this writing. A preliminary verbal report received by WCDSS from the medical examiner, noted no indication of intentional or accidental physical force to have caused the child's death and noted the child's toxicology report was negative for toxic substances.

At the time of the child's death, the child resided with his father and mother, his 8-year-old, 6-year-old, and 1-month-old siblings, and his adult half-sibling. Through interviews with law enforcement, WCDSS discovered that on 12/18/2021 the family had a gathering at their home, during which the subject child was observed to be well, playing video games, eating pizza, and playing with his 6-year-old brother. The subject child went to sleep on the living-room couch sometime around 12:00 AM on 12/19/2021. The OA observed the subject child, presumably asleep, on the couch around 7:00 AM, again between 9:00 and 10:00 AM, and again between 11:00 and 11:30 AM. Upon seeing the subject child still on the couch after 11:00 AM, the OA woke the subject parents. The subject father and OA attempted to wake the subject child but there was no response. The family contacted 911 at 11:48 AM. Emergency services responded to the home and the subject child was transported to a local hospital where he was declared deceased some time before 1:30 PM. WCDSS was informed that LE had interviewed the subject father, subject mother, other adult, and 6-year-old surviving sibling and none were able to provide any explanation for the subject child's death. LE saw all family members while completing interviews at the home and noted no concerns for the state of the home or for the surviving children in the care of the parents.

WCDSS had limited contact with the family due to their unwillingness to engage with the investigation. WCDSS was able to meet face-to-face with the mother and the surviving siblings via a video-chat and assessed the children to be safe in the home and in the care of the parents. WCDSS attempted further contact with the family and the mother again declined to engage. WCDSS acted appropriately in referring the matter to their legal department for consultation.

WCDSS did not find evidence to substantiate the allegations in the report, the surviving siblings were deemed to be safe, and the case was unfounded and closed. WCDSS made a referral through Victim Assistance Services after discussing bereavement services with the mother, however the mother declined to engage with these 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

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:
The decision to close the case was appropriate. There were no safety concerns found for the surviving siblings and no information gathered to indicate the subject child's death was the result abuse or neglect. Supervisory consultation is documented throughout the case record.

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: 12/19/2021 **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: 11:48 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? No - Not needed given developmental age or circumstances

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	Adult Sibling	No Role	Male	20 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	52 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

LDSS Response

WCDSS contacted the source of the initial SCR report on 12/19/2021 and gathered information regarding the responses of LE and EMS. WCDSS learned that LE had interviewed the SF, SM, OA, and the 6yo SS. It was reported to LE the family had a "get together" on the evening of 12/18/2021. The SC had been in the living room playing video games and eating pizza throughout the evening and had fallen asleep on the living room couch around 12:30 AM on 12/19/2021. The OA reported he had seen the SC still asleep on the couch around 7:00 AM and again between 9:00 and 10:00 AM. The OA stated he woke up the SF and SM around 11:00 AM and the family tried to wake the SC but there was no response. The 6yo SS reported to LE that he and the SC had been "play fighting" the night of 12/28/2021 and that he had kicked the SC in his stomach. The interviews revealed no explanation for the SC's death and raised no concerns for the surviving siblings. WCDSS was further informed that LE observed all of the SSs and reported no concerns for their safety or the safety of the family's home. The District Attorney noted that an autopsy of the SC would be completed the next week and that a CAC interview would be set up for the 6yo SS, also the next week. No mention was made of an interview for the 8yo SS and, further, the record does not reflect that any CAC interview ever took place.

WCDSS contacted SM on 12/19/2021 and SM reported the family would not be available for a home visit. WCDSS contacted the SM via telephone on 12/20/2021 to arrange for a face-to-face home visit which the SM refused. WCDSS requested to meet with the family via a ZOOM video-call and the SM agreed to this. WCDSS spoke briefly with the SM who reported the SC had been well when she went to sleep on 12/18/2021. The SM was crying profusely and WCDSS opted to stop questioning her about this matter. WCDSS spoke briefly with the 6yo and 8yo SSs who both stated they were doing well. WCDSS observed the 1-month-old SS to be asleep in his crib on his stomach and advised the SM to reposition the child as this was an unsafe position.

WCDSS spoke further with the SM via telephone on 1/3/2022 to discuss safe sleep in detail. The SM reported knowledge of safe sleep practices and stated the 1-month-old was seen asleep on his stomach as the SF, who did not wish to be seen on the video-call, had been holding the 1-month-old until the child needed to be seen on the video-chat and quickly placed the child in his crib positioned on his stomach for that moment. During the call, the SM reported that neither she nor her family would be willing to meet with WCDSS, face-to-face or otherwise. The SM did agree that she would remain available via telephone. The SM also stated that the SF would be writing a letter to WCDSS expressing their wishes to be left alone during this difficult time.

WCDSS reviewed the family's CPS history in a timely manner. Supervisory direction was documented throughout the case notes, as was consultation with WCDSS's legal department due to the family's refusal to allow WCDSS access to the home and SSs. WCDSS gave the family a referral for bereavement services and the SM declined to engage. WCDSS requested LE records. At the time of this writing they have not been made available.

WCDSS spoke with the ME and learned that an autopsy had been completed, however the autopsy report was not yet finished as of the time of this writing. The ME reported finding no indication that any accidental or intentional injury caused the death of the SC and added that the SC's toxicology was negative for toxic substances.

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 referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059678 - Deceased Child, Male, 9 Yrs	059679 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
059678 - Deceased Child, Male, 9 Yrs	059679 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
059678 - Deceased Child, Male, 9 Yrs	059680 - Father, Male, 52 Year(s)	DOA / Fatality	Unsubstantiated
059678 - Deceased Child, Male, 9 Yrs	059680 - Father, Male, 52 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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 did attempt to engage the family on multiple occasions, however the family declined to engage.

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: WCDSS did offer bereavement counseling through Victim Assistance Services, however this was declined by the family.				

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:
SM was offered and declined bereavement services. No other services were offered as the family did not engage with WCDSS.

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? No
Explain:
Although services were offered to the SM, she declined to engage.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WDCSS referred SM to Victim Assistance Services to facilitate bereavement counseling, however the SM declined 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? No
Was the child acutely ill during the two weeks before death? No

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

06/12/2017 – 07/27/2017 UNF against SM for IG and LSUP regarding the now 6-year-old SS.

Known CPS History Outside of NYS

There is no known 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