Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-22-038

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

Issue Date: Mar 03, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 3 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 10/03/2022
Initial Date OCFS Notified: 10/03/2022

Presenting Information

Westchester County Department of Social Services (WCDSS) received an SCR report on 10/3/22 which alleged on 10/2/22, the father burped the 3-month-old child, and then put him to sleep face up, on the couch. The father slept on the other end of the couch. The mother returned home from her overnight work shift at approximately 6:10AM on 10/3/22, and woke the father. The mother and father then both found the infant face down and unresponsive on the end of the couch. A neighbor heard the parents screaming, came to the home, and transported the family to the nearest hospital. The infant was pronounced dead at 6:32AM on 10/3/22. It was believed the unsafe sleep situation contributed to the infant's death. The role of the mother was unknown.

Executive Summary

This report concerns the death of the 3-month-old subject child. WCDSS received an SCR report regarding the child's death on 10/3/22. At the time of the child's death, he resided with his mother and father. There were no additional children in the home.

On 10/3/22, after being given a bottle at 1:30AM, the father laid the child down to sleep on a donut shaped Boppy Pillow, which was placed on a reclined couch. The father laid the child on his back, and the child was positioned facing the television. The father then sat down on the opposite end of the couch, intending to watch television until the mother returned from her overnight work shift; however, the father fell asleep. The father did not wake until the mother returned home about 6:10AM. The mother asked where the child was and that is when the father found the child face down, on his stomach, in-between the couch pillow and Boppy Pillow. The father picked up the child and he was unresponsive. The father attempted CPR and the mother called 911. Additionally, the mother ran out of the apartment and yelled for help, to which the upstairs neighbor responded. The mother and neighbor also attempted CPR to no avail. Ultimately, the neighbor drove the family to the nearby hospital as EMS had not yet responded to the home. The father ran into the emergency department holding the child. The child presented with rigor onset upon arrival and was pronounced dead at 6:32AM.

The medical examiner was notified and performed an autopsy of the child. The final autopsy was not received by WCDSS at the time the investigation closed; however, the medical examiner reported the cause of death was most likely suffocation due to the unsafe sleep environment. Law enforcement had not made any arrests.

WCDSS substantiated the allegations against the parents, having added the allegations of Inadequate Guardianship and DOA/Fatality against the mother during the open investigation. WCDSS found that a minimum degree of care was not provided by either parent, and as a result of the unsafe sleeping condition the child was placed in on 10/3/22, his physical safety was impaired, resulting in his death. Although the mother admitted to regularly co-sleeping with the child, the record did not contain information that the mother placed, directed the father to place, or was aware the infant was placed in the unsafe sleep environment specific to the fatal event on 10/3/22. The record did not support the addition and indication of DOA/Fatality against the mother, therefore the allegation was incorrectly determined.

The parents were offered bereavement services and accepted.

PIP Requirement

WCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) WCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently

implemented, WCDSS will review the plan and revise as needed to address ongoing concerns.

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?** No

Explain:
WCDSS inappropriately added and substantiated the allegation of DOA/Fatality against the mother.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The parents engaged in bereavement counseling prior to the investigation closing. Casework activity was not commensurate with appropriate and relevant statutory or regulatory requirements as the DOA/Fatality allegation was incorrectly added and substantiated by WCDSS.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	WCDSS substantiated the allegation of DOA/Fatality against SM stating SM had safe sleep education, was aware of the warning label on the pillow, and regularly co-slept with SC. Causation specific to the death on 10/3/22 for SM was not established.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	WCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Westchester Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/03/2022 **Time of Death:** 06:32 AM

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: 06:18 AM
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ 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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)

LDSS Response

On 10/3/22, WCDSS received a report regarding the death of SC. WCDSS initiated their investigation within 24 hours and coordinated with LE. WCDSS contacted the source of the report, completed a CPS history check regarding the family, and coordinated with the DA. WCDSS learned there were no surviving children in the home and the initial home visit was conducted on 10/4/22.

WCDSS asked the parents to describe the 24 hours leading up to SC's death. SF worked overnight the night prior, and arrived home at 6:20AM on the morning of 10/2/22. SM was co-sleeping with SC in bed and SF got into the same bed and fell asleep. SC woke at 8:00AM, SM breastfed SC, and they both went back to sleep until 10:00AM, at which time SC woke to feed again. SC was described as teething and fussy, and was given medication for congestion; however, threw up the medicine. At 11:00AM or 12:00PM, the paternal grandfather visited the family and stayed until 4:00PM or 5:00PM. SC was fed and burped at 5:00PM and SM took SC for a walk outside at 6:00PM. At the same time, SF left the home to walk the dogs and go to the store and SF returned at 7:45PM. After feeding SC at 8:00PM, SM got ready for work and left the home at 9:40PM for her overnight shift. At 11:00PM, SF bottle fed SC 4oz of breastmilk. At 12:30AM, SM returned home for her lunch break and attempted to feed SC; however, SC did not eat so SM laid in the bed with SC until she left to return to work at 1:00AM. SC became fussy at 1:30AM, had 1oz of breastmilk, and SF held and walked SC around the

living room to settle him. SF then placed SC to sleep on top of a donut shaped Boppy Pillow, which was placed on the right side of the reclined couch. SC was placed on his back, with his head positioned to face the television. SF sat down on the opposite side of the couch to watch television; however, unintentionally fell asleep. SF was awoken to SM returning home around 6:10AM. SF got up from the couch and opened the door for SM. SM asked where SC was. SF looked over to the couch but did not immediately see SC. SF found SC face down, on his stomach, in-between the couch pillow and Boppy Pillow. SF picked up SC. SC appeared red in color, his body was warm and limp, and he was not breathing. SF observed blood on SC's mouth and SC had chapped lips. Both parents attempted CPR and SM called 911. SM ran out of the apartment, screaming for help, and the upstairs neighbor responded. The neighbor came downstairs and attempted CPR as well. EMS had not yet responded so the neighbor drove SM, SF, and SC to the nearest hospital. SF ran into the emergency department holding SC. SC's body was stiff upon arrival to the hospital and SC was pronounced dead at 6:32AM.

WCDSS interviewed the upstairs neighbor who responded to SM's calls for help. The neighbor reported SC was pale in color when he saw him, and his lips were chapped. The first thing he did was feel for a pulse, which he did not detect. The neighbor then attempted CPR before driving the family to the hospital.

WCDSS spoke with the ME, who reported SC did not have any signs of inflammation and that the child arrived at the hospital already with lividity and rigidity. The ME stated the cause of death was most likely suffocation due to unsafe sleep.

WCDSS contacted numerous collaterals, including LE, the DA, the ME, SC's pediatrician, and reviewed birth records. Records were requested from the treating hospital regarding the fatality; however, the record did not reflect if those records were received or reviewed. Bereavement services were offered to the parents, which they accepted. There were no surviving children in the household and no criminal charges were brought against either parent regarding the fatality.

WCDSS substantiated the allegations of IG and DOA/Fatality against SF and during the investigation added and substantiated the same allegations against SM. The investigation was indicated and closed.

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
061751 - Deceased Child, Male, 3 Mons	061753 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated
061751 - Deceased Child, Male, 3 Mons	061753 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
061751 - Deceased Child, Male, 3	061752 - Mother, Female, 19	DOA / Fatality	Substantiated

Mons	Year(s)		
061751 - Deceased Child, Male, 3 Mons	061752 - Mother, Female, 19 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:
Emergency room records were requested; however, the record did not contain information that they were received or reviewed prior to the case closing.

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	Offered, but	Offered, Unknown	Not Offered	Needed but	N/A	CDR Lead to

	Death	Refused	if Used		Unavailable		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 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 surviving siblings or other children residing in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were engaged in bereavement counseling prior to the case closing and were provided mental health mobile crisis resources.

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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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 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