Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-053

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

Issue Date: Dec 22, 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: 1 year(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 09/06/2023
Initial Date OCFS Notified: 09/06/2023

Presenting Information

An SCR report received on 9/6/23 alleged that on that day, the father was the sole caretaker to the 1-year-old subject child. At 12:00PM, the father laid the child down for a nap in an unknown location. At an unknown time, the father observed the child unresponsive and lying in his own vomit. The father began cardiopulmonary resuscitation (CPR) to revive the child. The father contacted 911, but when the ambulance failed to arrive, the father brought the child to the hospital. At 2:35PM, the child arrived at the hospital in cardiac arrest and the medical team performed lifesaving measures to resuscitate the child. At 3:14PM, the child was pronounced deceased. The child was otherwise healthy, and the father had no explanation for the death. The roles of the mother and siblings were unknown.

Executive Summary

This report concerns the death of the 1-year-old subject child. Westchester County Department of Social Services (WCDSS) received an SCR report regarding the child's death on 9/6/23. At the time of the child's death, he resided with his mother, father, and twin 8-year-old siblings.

On the morning of 9/6/23, the subject child woke up at his usual time and the morning continued in its typical manner without concern. The mother was home with the child and siblings, and the father returned from work around 11:00AM for his lunch break. Around noontime, the father offered the child chicken and rice for lunch, which the child pushed away. The child was then given Gerber Lil' Crunchies and a bottle of whole milk. While the child drank the bottle of milk, the father changed his diaper and clothes, then laid down on the parents' bed with the child until the child fell asleep. Once the child was asleep, the father got up and got ready to return to work, leaving the home around 1:43PM. The mother cooked lunch for herself and the siblings, and next checked on the subject child at 2:20PM. The mother was on the phone with the father at that time, as they typically spoke on the phone with one another throughout the day, and noticed vomit on the bed, and then observed the child's lips and fingers were blue. She picked up the child and said to the father, "oh my God, he's not breathing!" The father worked next door and immediately came home while the mother was calling 911. The mother's 911 call was rerouted by dispatch and the father attempted CPR while the mother continued attempts to get through to 911. While attempting CPR, vomit came out of the child's nose. The family decided to drive the child to the nearby hospital and the mother notified dispatch that they were enroute to the hospital. Upon arrival to the hospital at 2:35PM, the father ran inside with the child. The child was in cardiac arrest and life-saving measures were attempted; however, the child was pronounced deceased at 3:14PM.

The medical examiner was notified and performed an autopsy on the child. The final cause and manner of death were pending at the time the CPS investigation was closed. No bruising or trauma was found to the child's body. Toxicology results were negative, and the only medications found in the child's system were those used by the doctors in efforts to revive the child. There was no evidence of suffocation. The child was noted to be above average in weight and size for his age. The child's tonsils were found to be enlarged, and the medical examiner posited it was possible the child's airway became obstructed if he vomited along with his tonsils already being enlarged, but did not think that was the case, as they did not see aspiration to the lungs or bronchioles, nor liquid accumulation in the back of the mouth. A small number of bacteria (Group A streptococcal) was found in the lungs and throat but would not have contributed to the death. Human echovirus 25 was found in the blood and lungs, though no inflammation to organs was observed. The medical examiner stated it appeared the parents were appropriate, they found no signs of abuse, and at that time, there was no explanation for the child's death. Law enforcement found no criminality associated with the death and no arrests were made.

WCDSS made several home visits at the onset of the investigation and interviewed the parents and siblings. The siblings were assessed to be safe. Following initial discussions, the parents declined further interviews.

WCDSS made the appropriate determination and unsubstantiated the allegations of DOA/Fatality and Inadequate Guardianship against the father regarding the subject child. WCDSS found no preponderance of evidence that either parent caused or contributed to the death, or that either parent failed to provide a minimum degree of care to any of the children in the household.

The family declined bereavement services offered by WCDSS.

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:
WCDSS made a determination in congruence with the evidence found throughout the investigation, and the report was unfounded. Although it was learned the mother was the caretaker to the child at the time of his death, it was decided ultimately not to add allegations as they could not be substantiated.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 09/06/2023 **Time of Death:** 03:14 PM

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: 02:24 PM
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	48 Year(s)
Deceased Child's Household	Mother	No Role	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Other Household 1	Sibling	No Role	Male	19 Year(s)
Other Household 2	Other Adult - 8yo Twins' Father	No Role	Male	38 Year(s)

LDSS Response

On 9/6/23, WCDSS received a report regarding the death of the subject child. WCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. WCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. WCDSS assessed the safety of the siblings and conducted an initial home visit the day the report was received.

WCDSS interviewed the parents regarding the events leading up to the child's death. The family had recently returned from a cruise; no one in the family had been ill and the children had remained in the parents care throughout the duration of the trip. In the early morning of 9/6/23, the father left the home at 5:00AM for work, which was in the building next door. The mother remained home with the subject child and siblings. The child woke around 7:30AM, was given a bottle of milk, and engaged in what was described as his normal routine of running around the home and pulling pillows off the

couch. Typically, either the mother or father would put the child down for a nap. The child was always given a bottle to fall asleep with; however, the parents would lay in bed with the child until he finished the bottle and did not allow him to have the bottle unsupervised. That day, the father returned home for lunch at 11:00AM and he stayed with the child until the child fell asleep for his nap. The father then left at 1:43PM to return to work and the mother cooked cheeseburgers for herself and the siblings, which they ate while watching TV. It was normal for the parents to talk with one another on the phone throughout the father's workday, and they were on the phone with each other when the mother went to check on the child at 2:20PM. When she got to the bedroom, she saw vomit on the bed. She picked up the child and started screaming, stating she had to call 911 and ended the call with the father. The mother called 911 but the call was repeatedly rerouted. The father came home and initiated CPR while the mother continued calling 911. While attempting CPR, vomit came out of the child's nose and the father said it smelled like the milk and snack the child had eaten before his nap. The father decided to drive the child to the hospital. The car was downstairs, and the ambulance had not arrived. The family, including the siblings, got into the car and the mother took over CPR while the father drove. They stayed on the phone with dispatch and notified them of what hospital they were going to. Upon arrival, the father ran inside the hospital with the child and was met by medical staff and law enforcement.

WCDSS interviewed the siblings. One twin's recollection reflected that of the mother's; however, the other twin reported he was outside with his 19yo brother at the time of the incident and learned of the death when he returned to the apartment and called the mother because no one was home. The mother told him they were at the hospital. WCDSS was unable to re-interview the sibling per the mother's request and the mother maintained both siblings were in the home during the fatal incident, and they all traveled to the hospital together. Attempts were made to no avail to contact the 19yo sibling. The twins' father did not have any concerns for the wellbeing of the siblings and stated the mother was a great mother.

Numerous collaterals were contacted, including the children's pediatrician, who had been the family's doctor since the twins were born and described them as an "amazing family." No concerns were noted for any of the children, they all received routine care and the subject child was last seen on 7/13/23 with no concerns. School records reflected the siblings had excellent attendance and grades. Services were offered to the family, and they declined. At the close of the investigation the siblings were assessed as safe. The report was unfounded, and the investigation closed on 11/3/23.

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
065482 - Deceased Child, Male, 1 Year(s)	065484 - Father, Male, 48 Year(s)	DOA / Fatality	Unsubstantiated
065482 - Deceased Child, Male, 1 Year(s)	065484 - Father, Male, 48 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:

Attempts were made to interview the 19yo sibling, as he was named on the report and allegedly was with one of the 8yo siblings at the time of the fatal incident. The 19yo did not respond to WCDSS and the parents would not provide contact information.

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	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
Bereavement services were offered to the parents on behalf of the siblings. The mother declined, stating she did not wish to have the siblings engage in bereavement services as she felt it would cause more grief. The mother stated she wanted to keep the siblings' schedule as normal as possible so they did not miss school or extracurricular activities following the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Bereavement services were offered to the parents. While initially receptive, the mother ultimately declined services on behalf of the family. They were provided contact information for services if they changed their mind in the future.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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

In January 2019, WCDSS received an SCR report alleging domestic violence against the father with another paramour, in the presence of the 14-year-old (now 19-year-old) sibling and a then 9-month-old sibling shared by the father and paramour. The allegation of Inadequate Guardianship was unsubstantiated against the father, as WCDSS found no evidence that the children were present or witnessed the disagreements between the adults or were impacted by the adults' issues in the home. At the close of that investigation, the paramour and 9-month-old sibling relocated out of state. Attempts to gather updated contact information for the paramour and sibling during the fatality investigation were

unsuccessful; however, a Notice of Existence letter was mailed to the last known address.

In November 2013, the Administration for Children's Services (ACS) received an SCR report alleging that the father and his paramour got into a verbal argument and the father physically assaulted the paramour, causing injury to both her eyes in the presence of the 9-year-old (now 19-year-old) sibling. The allegation of Inadequate Guardianship was unsubstantiated against the father as the child reported there was no hitting, punching, or slapping. Rather, the father was trying to "wrestle" a knife away from the paramour, who was using it to cut up the father's clothing.

Known CPS History Outside of NYS

There was no known CPS 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