Child Fatality Report

Report Identification Number: SV-21-042

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

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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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 day(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 10/06/2021
Initial Date OCFS Notified: 10/06/2021

Presenting Information

Westchester County Department of Social Services (WCDSS) received a report from the SCR alleging on 10/6/21, the father and mother fell asleep on the bed with the 5-day-old subject child. The child was laying on her back, cradled in her father's left arm. The mother was laying next to the father's right side. There were pillows at the top of the bed and a blanket covering the bed. Between 4:00AM and 4:30AM, the father felt the subject child move and he woke. At the time, the subject child was alive and there were no known injuries. The father woke to his alarm around 5:00AM and found the child pale and unresponsive. 911 was called and first responders arrived and began CPR. The child was transported to the hospital where she was pronounced dead at 6:31AM.

Executive Summary

This report concerns the death of the 5-day-old female subject child that occurred on 10/6/21. At the time of the subject child's death, she resided at home with her mother, father, and siblings, ages 12 and 8 years old. An autopsy was completed; however, the final report had not yet been issued at the time of this writing, and the cause and manner of death remained pending.

The investigation revealed the parents were in bed with the subject child on the morning of 10/6/21. The father had the subject child cradled in his left arm while he slept. Both parents confirmed there was a bassinet available for the child. The child typically slept in her bassinet, which was located in a room outside of the parents' bedroom. The child was awake and fussy around 1:00AM, so the father took the subject child out of the basinet and fed her a bottle while sitting in his bed next to the mother. The mother woke around 1:45AM and observed the subject child had fallen asleep. The mother told the father to place the subject child back in her bassinet and then the mother fell back to sleep. The father did not place the child in her bassinet but fell asleep in bed with the subject child in his arms. The father woke around 5:00AM and described the subject child as being "unresponsive" at that time. The parents called 911 and began CPR at the direction of the 911 operator. First responders arrived and transported the child to the hospital, though resuscitative efforts were unsuccessful, and the child was pronounced deceased at the emergency room.

WCDSS provided the parents with information for grief and mental health counseling. Community-based referrals were provided for the siblings, but the parents reported they were receiving support from their school. WCDSS spoke with family members and collateral sources, which included law enforcement, medical staff, and the medical examiner. WCDSS found credible evidence to substantiate the allegations of DOA/Fatality and IG against the father regarding the subject child. WCDSS determined the father was aware of safe sleep practice and was aware of the harm associated with co-sleeping. Despite that knowledge, the father chose to sleep in bed with the child. WCDSS unsubstantiated the allegations of DOA/Fatality and IG against the mother as she told the father to place the subject child back into the bassinet prior to falling asleep. The preliminary findings from the medical examiner reflected the sleeping environment was unsafe. No further service needs were identified and the investigation closed after all casework activity was complete. WCDSS conducted a thorough investigation in accordance with multidisciplinary standards and recorded casework activity and required assessments timely and accurately.

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:
The case was appropriately indicated and closed.

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: 10/06/2021 **Time of Death:** 06:31 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: 05:00 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? 30 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	Female	5 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)

LDSS Response

On 10/6/21, WCDSS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, WCDSS initiated their investigation within 24 hours and coordinated efforts with their MDT. WCDSS reviewed CPS history which revealed that neither the parents, subject child, nor siblings were known to the system.

WCDSS interviewed the parents immediately upon receipt of the report on 10/6/21. The parents reported the subject child was in bed with them in the early morning hours of 10/6/21. The father took the subject child out of her bassinet and brought her into the parents' bed to eat. The child ate approximately 3oz from her bottle around 1:00-1:30AM and then fell asleep while held in the father's arms. The mother woke around 1:45AM and encouraged the father to place the child back in her bassinet before falling back to sleep. The father continued holding the child in his arms and fell asleep a short time later. The father reported the subject child was cradled in his left arm, face up, swaddled in her hospital receiving blanket. The father woke around 4:30AM and noted the child was awake and moving in his arm. The child stopped moving, closed her eyes, and the father presumed she fell back asleep. At 5:00AM, the father woke and observed the subject child to be pale and not breathing. The father reported the child was still in his left arm, face up, and swaddled in her blanket. The parents called 911 and began CPR while awaiting the arrival of first responders. First responders transported the child to the hospital where she was pronounced deceased at 6:31AM.

Medical records revealed the child was born on 10/1/21 via c-section and there were no complications during the mother's pregnancy nor during the delivery. The child's first well baby appointment was scheduled for 10/6/21, the date of her death. Medical records regarding the siblings were received and there were no concerns documented.

The siblings were assessed to be safe in the care of their parents. No safety concerns were revealed for the surviving children, as the unsafe situation was isolated to the circumstances of the infant's vulnerability. Both siblings reported knowledge of the subject child's death, but the record did not reflect they were aware of the conditions surrounding the death.

Law enforcement advised WCDSS of their interviews with the family. Law enforcement corroborated the parents' account of the incident. Law enforcement determined there was no criminality or foul play suspected in the death and closed their investigation. A phone conversation with the medical examiner revealed the preliminary cause of death to be unsafe sleep, though he was awaiting histology results prior to making official the manner and cause of death. The appropriate fatality-related services were offered, and the case was closed upon sufficiently gathering information to determine the investigation.

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
Comments: WCDSS adhered to previously approved protocols for joint investigations by coordinating efforts with law enforcement and notifying the DA's office of the death.

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
059101 - Deceased Child, Female, 5 Days	059103 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
059101 - Deceased Child, Female, 5 Days	059103 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
059101 - Deceased Child, Female, 5 Days	059102 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
059101 - Deceased Child, Female, 5 Days	059102 - Mother, Female, 31 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:
All relevant collateral sources were contacted.

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 provided the family with community-based resources.				

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?	☐	☒	☐	☐
Explain as necessary: There was no removal of the siblings.				

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Victim Assistance Services (VAS)

Additional information, if necessary:
WCDSS provided referrals for community-based mental health and bereavement counseling to the family. A referral for Victim Assistance Services was made and the mother was participating in a Women's Group at the time the investigation closed.

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? Yes
Explain:
WCDSS provided referrals for community-based resources to the parents for the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS provided the parents with resources for community-based mental health and bereavement counseling.

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

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 was no known 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