Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-21-027

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

Issue Date: Feb 14, 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: 6 month(s)
Jurisdiction: Chautauqua
Gender: Male
Date of Death: 08/31/2021
Initial Date OCFS Notified: 08/31/2021

Presenting Information

An SCR report was received with concerns that on 8/31/21, between 6:00PM and 6:30PM, the mother and father fed the six-month-old subject child, then laid him face down in his crib to sleep. The mother and father then went to another room in the home to eat dinner. At approximately 8:30PM, the mother checked on the child and found him with vomit around his head, not moving or breathing. The mother picked the child up and called 911. The parents performed cardiopulmonary resuscitation on the child until emergency services arrived. The child was transported to the hospital where he was declared deceased. He was an otherwise healthy child and there was no plausible explanation for his death.

Executive Summary

This fatality report concerns the death of a six-month-old male subject child that occurred on 8/31/21. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother and father. Chautauqua County Department of Social Services received the report and investigated the child's death. An autopsy was completed; however, the official cause and manner of death remained pending at the time of this writing.

At the time of the child's death, he resided with his mother and father. There were no other children residing in the household; however, the father had two daughters, ages four and five years old, who lived with their mother. The investigation revealed that at approximately 6:30PM on 8/31/21, the father laid the subject child on his stomach in his portable crib. The portable crib also contained three blankets, one of which was a large comforter that the child had been placed on top of. After putting the child down to sleep, the father and mother had dinner in a separate room of the house. At around 8:45PM, the mother went to get ready for bed, and upon entering her room, she noticed the child did not stir as he normally would. The mother found the child face down in the crib, and when she turned him over, he was unresponsive. Emergency services were called and responded to the home. The child was transported to the local hospital where he was pronounced deceased at 9:30PM on 8/31/21.

CCDSS interviewed family members and collateral sources, including law enforcement, the medical examiner, the subject child's pediatrician, and service providers. The surviving half-siblings were assessed and deemed safe with their mother. There was no criminality found regarding the child's death. The child's pediatrician informed CCDSS that the parents had been educated more than once regarding safe sleep practices. Although the final autopsy report had not yet been released, conversations with the medical examiner indicated the cause of death was likely due to the unsafe sleeping environment the child had been placed in. Therefore, CCDSS indicated the report and closed the investigation.

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:
CCDSS gathered information to determine the allegations and assess the safety of the surviving half-siblings.

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 case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the 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: 08/31/2021 **Time of Death:** 09:30 PM

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

County where fatality incident occurred: Cattaraugus
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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? 2 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted
☐ Asleep
☐ Absent
☐ 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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

On 8/31/21, CCDSS received the SCR report regarding the death of SC, which occurred on that same date. CCDSS initiated their investigation within 24 hours and coordinated their efforts with their MDT.

On 9/1/21, CCDSS interviewed SM. SM reported she left for work at 5:00AM on 8/31/21 and SF stayed home with SC. SM said SC also had his 6-month checkup, which SM took him to at 3:00PM. SM said SC had immunizations and there were no concerns. SM said when they arrived home, SC was laughing and smiling and acting normally, but around 6:30PM, SC became very fussy and tired. SM explained SC did not have a fever and there were no changes to his breathing. SF then laid SC down on his stomach in the crib, and he had tried to feed SC prior to laying him down, but he did not want it. The crib contained one large comforter and two additional blankets. SM reported SF then left the room, and she and SF ate dinner and watched TV. SM said she was getting ready for bed around 8:45PM and noticed SC did not stir as he usually did when she entered the room. SM explained SC was face down, and she rolled SC over onto his back and found him not breathing. She stated she called 911 and started CPR. SM said SC was born premature at 26 weeks gestation and spent 86 days in the hospital; however, once released he had no additional medical needs or concerns. SM reported SC had an inhaler, but his doctor told her he did not need it. She did not believe SC received a dose of the inhaler on the date of his death. On this same date, CCDSS interviewed SF, and his recollection of events corroborated SM's. He reported SC was acting fine and had not been ill. He had no additional information to provide regarding the incident.

On 9/1/21, CCDSS assessed the safety of the SSs and observed their home. There were no concerns noted. The SSs were interviewed and reported they felt safe with their mother and with SF and SM.

On 9/7/21, CCDSS spoke with the early intervention coordinator involved with the family. The coordinator reported she was last in the home on 8/31/21 at 11:00AM, and SC was starting to roll over and smiling. She reported that was his best session yet and she had no concerns. The coordinator said both parents were present during that session and were engaging and appropriate.

On 9/13/21, CCDSS spoke with SC's doctor. The doctor reported SC was up to date medically, gaining weight, and his lungs were clear when he was last seen on 8/31/21. The doctor explained SC was born in another state, and that was where he was prescribed an inhaler. She said SM reported only administering the inhaler once weekly instead of once daily, as the directions noted. SC saw a specialist regarding this in June 2021 and had a follow up scheduled for September. The record did not reflect if there was any possible negative effects from SC not receiving his inhaler as prescribed; however, the doctor reported SC was healthy and she had no concerns for his lungs or his breathing. The pediatrician also reported she discussed safe sleep practices with SM.

Throughout the investigation, CCDSS spoke with family and collateral sources. There were no criminal charges brought against either parent regarding the fatality. CCDSS provided grief and bereavement counseling referrals to SM and SF; however, they declined needing services. The ME reported there were no signs of trauma found during autopsy, and SC appeared to be a healthy infant. She noted an old subdural hematoma but said this was probably from the birthing process and was not related to SC's death. CCDSS found evidence that the parents placed SC in an unsafe sleeping environment, and a causal link was established after the ME opined the death was mostly likely due to such. Therefore, the allegations were substantiated, and the case was 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
Comments: This fatality investigation was conducted by the Chautauqua County Multidisciplinary Team.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Chautauqua County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059421 - Deceased Child, Male, 6 Mons	059422 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
059421 - Deceased Child, Male, 6 Mons	059422 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
059421 - Deceased Child, Male, 6 Mons	059423 - Father, Male, 27 Year(s)	DOA / Fatality	Substantiated
059421 - Deceased Child, Male, 6 Mons	059423 - Father, Male, 27 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?	☒	☐	☐	☐
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:
CCDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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: CCDSS offered the family services in response to the child's death.				

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: The subject child's two surviving half-siblings resided with their mother and were deemed safe by the close of the investigation. There were no other children living in the subject child's 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 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:
CCDSS provided the parents with bereavement counseling referrals and information on assistance with funeral costs. Service referrals were also provided to the surviving half-siblings' and their mother following the fatality.

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:
CCDSS provided the mother of the surviving half-siblings referrals for services for the half-siblings if needed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief and bereavement service referrals were provided to the parents following the fatality.

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 fetal alcohol effects or syndrome

☒ With neither 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

From 2012 to 2016, the father was named as a nonconfirmed subject in two unfounded CPS investigations. These investigations had common allegations of IF/C/S and SA regarding minor relatives living in the home.

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