Child Fatality Report

Report Identification Number: BU-21-010

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

Issue Date: Sep 07, 2021

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: Female
Date of Death: 03/15/2021
Initial Date OCFS Notified: 03/15/2021

Presenting Information

An SCR report alleged on 3/15/21, the father gave the 6-month-old female subject child a bottle and laid her down in a playpen for a nap around 1:15 PM. At 1:39 PM, the father checked on the child and she was unresponsive and had difficulty breathing. The mother was present when the child became unresponsive. The father performed CPR and formula came out of the child's mouth. A family member was called and the family member called 911. The parents drove the child to the hospital and when they arrived, the child was warm and had normal color. The child was pronounced deceased at the hospital. The parents had no explanation for the death as the child was otherwise healthy. There was blood near the child's rectum which may have occurred from the death or from the attempted CPR. There were no visible injuries on the child's body.

Executive Summary

This fatality report concerns the death of the 6-month-old female subject child that occurred on 3/15/21. A report was made to the SCR on the same day alleging the child was found unresponsive while in the care of her parents and subsequently died without a plausible explanation for her death. At the time of the child's death, she resided with her parents. The father had a 6-year-old child who did not have a relationship with the subject child; however, she was assessed to be safe in the care of her mother.

Chautauqua County Department of Social Services (CCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The parents had a history of police involvement due to domestic violence prior to the child's birth. The criminal investigation did not result in any charges. An autopsy was performed; however, the results were pending at the time this report was written. The medical examiner reported there was a possibility the child died as a result of accidental positional asphyxia.

The parents reported the child was placed in a Pack 'N Play for a nap around 1:15 PM. Soon thereafter, the father checked on the child and found the child to be unresponsive. The father alerted the mother and 911 was called. The parents did not wait for EMS to arrive and transported the child to the hospital themselves. The child was unable to be revived and was pronounced deceased.

CCDSS gathered information from collateral contacts including hospital staff, the pediatrician, coroner and medical examiner. There were initial concerns for the child's sleeping environment as law enforcement observed multiple blankets inside of the Pack 'N Play; however, the father said he threw the blankets off the parents' bed and into the Pack 'N Play after he found the child unresponsive. Law enforcement did not find evidence the child was placed on top of the blankets the father threw into the Pack 'N Play.

CCDSS completed home visits and interviews with the parents were thorough. The Risk Assessment Profile was completed with accuracy. The family was offered mental health counseling, grief counseling and domestic violence advocacy. Before the child was born, the father yelled, threw and broke things. It remained unknown if the parents utilized the services.

The allegations of Inadequate Guardianship and DOA/Fatality were unsubstantiated against the parents. CCDSS determined there was no credible evidence to support the parents placed the child at risk of harm; however, the record reflected the parents had placed the child to sleep in the Pack 'N Play with a foam insert and folded blankets for added

cushioning. Additionally, the child had a blanket at her feet. The medical examiner reported a possible cause of death was accidental positional asphyxia, which provided some credible evidence. The investigation was closed on 5/14/21.

PIP Requirement

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

The decision to unfound the investigation was not appropriate with regard to case circumstances.

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:

No Safety Assessment was required as there were no surviving children residing in the home or in the care of the parents. The casework activity was not commensurate with case circumstances as the record did not reflect written notice of the SCR was provided to the parents. Additionally, the allegations were not determined appropriately.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The record did not reflect the parents were provided with written notice of the SCR report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	CCDSS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Issue:	Appropriateness of allegation determination
Summary:	Although the record reflected the ME reported the child may have died as a result of accidental positional asphyxia, and the parents and law enforcement described an unsafe sleeping environment, the allegations were unsubstantiated.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	CCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Buffalo Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/15/2021 **Time of Death:** 02:15 PM

Time of fatal incident, if different than time of death: 01:30 PM

County where fatality incident occurred: Chautauqua
Was 911 or local emergency number called? Yes
Time of Call: 01:38 PM
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? N/A
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? 15 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **In another room**

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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

On 3/15/21, CCDSS received the SCR report and immediately began their investigation into the death. Within the first 24 hours of the investigation, CCDSS contacted the source of the report, documented a CPS history check, coordinated investigative efforts with law enforcement, and notified the district attorney's office of the death. The medical examiner's office had already been made aware of the death.

Prior to CCDSS's involvement, law enforcement learned from hospital staff that the father placed the child in a Pack 'N Play around 1:15 PM on the day of her death. Around 1:40 PM, the father checked on the child and found her unresponsive. The mother was in the shower at the time and the father notified her of the child's condition. The mother called the maternal grandmother who spoke with her partner. The grandmother's partner advised 911 be called. Although 911 had been called, the parents drove the child to the hospital in their vehicle and chest compressions were performed. The mother said the child was asleep on and off the night prior to her death and believed it to be from discomfort due to the child's ears being pierced that day. Initially, law enforcement said the Pack 'N Play was not a safe sleep environment for the child as there was a memory foam mattress folded in half and multiple blankets inside of it. It was later learned the father threw the blankets off the parents' bed into the Pack 'N Play prior to laying the child down to perform chest compressions. There was no evidence to support that any weight, including the child, was placed on top of the blankets.

The parents were interviewed at the home. The parents' recollection of the fatal incident corroborated what was reported to law enforcement. In addition to the information provided by law enforcement, the parents stated the child was awake hourly the night prior to her death. The child was given a pain reducer as she had her ears pierced that day. The father reported feeding the child and placing her in the Pack 'N Play after she fell asleep. When he checked on the child 15-20 minutes later, the child had rolled from laying on her back to laying on her side. The child was unresponsive and limp. The father told the mother about the child's condition and began performing chest compressions as formula came out of the child's mouth. The maternal grandmother was called and subsequently EMS was contacted. The parents drove the child to the hospital where she was pronounced deceased.

Hospital staff provided information the parents arrived at the hospital and were screaming the child was not breathing. CPR was performed by medical staff; however, the child passed away. There were no marks or bruises observed on the child.

The medical examiner confirmed there was no injury or trauma found on the child's body during the preliminary autopsy. The medical examiner stated she believed positional asphyxia could have played a role in the child's death; however, the autopsy was not yet completed at the time of case closure.

The parents were interviewed again prior to case closure. The father said there were folded blankets on the bottom of the Pack 'N Play for extra cushioning and a blanket was at the child's feet. The mother reported there was a foam insert on the bottom of the Pack 'N Play to make the sleep surface softer for the child. The mother said the parents had co-slept with the child regularly until approximately a week prior to the child's death as the pediatrician was adamant about safe sleep practices.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The death was referred to the CFRT during the course of the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057932 - Deceased Child, Female, 6 Mons	057933 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
057932 - Deceased Child, Female, 6 Mons	057933 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
057932 - Deceased Child, Female, 6 Mons	057934 - Father, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
057932 - Deceased Child, Female, 6 Mons	057934 - Father, Male, 25 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?	☒	☐	☐	☐

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?	☐	☐	☒	☐
Explain: The father had a 6-year-old child who did not have a relationship with the father as there was a stay-away order of protection. The order was granted as the father punched the sibling's mother. The sibling was observed; however, no interview was conducted as the sibling did not have a relationship with the child nor would the sibling have information regarding the death or the child's safety. Safety Assessments were not required as the sibling was not listed on the report.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
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 were no surviving children residing 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 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:
It remained unknown if the parents utilized the services that were offered to them. The record did not reflect funeral assistance was offered to the parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered mental health and grief counseling services in response to the death.

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

3/2/16- 4/8/16 The father was unsubstantiated for Inadequate Guardianship regarding the sibling.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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