Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-21-013

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

Issue Date: Nov 01, 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: 4 month(s)
Jurisdiction: Steuben
Gender: Female
Date of Death: 05/07/2021
Initial Date OCFS Notified: 05/07/2021

Presenting Information

Steuben County Department of Social Services (SCDSS) received an SCR report on 5/7/2021 which alleged that the 4-month-old subject child (SC) had been found unresponsive in her bassinet by the mother (SM). The mother yelled to the father (SF) for assistance, and they initiated CPR. The child was pronounced dead in the home on 5/7/2021. The roles of the surviving siblings, ages 1 and 2 years old are unknown.

Executive Summary

This report concerns the death of a 4-month-old which occurred while in the care of her mother and father. SCDSS received the SCR report and coordinated their response with law enforcement and notified the district attorney of the child's death.

SCDSS conducted familial interviews in the home and were informed by the parents that the child had been placed to sleep on her stomach in the parents' bed at 5:30 PM on 5/6/2021. The mother checked on the child periodically until approximately 10:00 PM when she checked on the child with the intention of feeding her and changing her diaper before placing her in the bassinet to sleep for the night. The mother found the child to be cold to the touch and not breathing. The mother and father started to perform CPR before ceasing lifesaving efforts. The father then informed the mother's uncle, who lived next door to the family, of what had happened. The uncle was informed by another member of the community that he needed to call 911, which occurred more than two hours later at 12:15 AM on 5/7/2021. The child was pronounced dead in the home at 1:20 AM on 5/7/2021. The parents stated they had no previous knowledge of safe sleep practices. Law enforcement conducted their interviews with the family prior to SCDSS involvement and corroborated the story of events with the interviews they had conducted.

SCDSS contacted the midwife who delivered the child and performed her initial follow up care. The midwife identified no medical concerns and stated that she counseled all families she worked with about safe sleep practices, though she could not provide specific documentation that safe sleep practices were reviewed with the mother and family when asked by SCDSS. The midwife identified that she counseled all families on safe sleep practices due to the common practice within their community to place a child to sleep on their stomach or side if they did not sleep well on their backs.

The final autopsy report was not available at the time the investigation was closed; however, in an interview with SCDSS, the medical examiner indicated that the cause of death was consistent with an unsafe sleep environment, pending the results of the toxicology report.

SCDSS made the determination to unsubstantiate the allegations of DOA/Fatality and Inadequate Guardianship against the parents regarding the child despite the evidence the child's death was related to an unsafe sleeping environment. The child was placed to sleep on her stomach on a quilt while wearing a dress, a bib, and a hat. The 2-year-old and 1-year-old siblings were assessed as being safe in the care of the mother and father throughout the investigation. The investigation was closed prior to the final autopsy results being made available. Counseling and additional services were declined by the family, citing the support within their community.

PIP Requirement

SCDSS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the LDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS 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:**
  - **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?** No

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:

There were detailed casework conferences throughout the investigation and the decision to close the investigation was made in conjunction with supervisory consult. The determination of the allegations was made incorrectly, as there was evidence presented to say that the SC died due to the unsafe sleep conditions.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The investigation revealed credible evidence to substantiate the allegations of IG and DOA/Fatality due to the parents placing the SC in an unsafe sleep environment. The ME noted the cause of death was consistent with an unsafe sleep environment.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	SCDSS will refer to the CPS Program Manual and/or consult with the Rochester Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/07/2021 **Time of Death:** 01:15 AM

Date of fatal incident, if different than date of death: 05/06/2021
Time of fatal incident, if different than time of death: 10:00 PM

County where fatality incident occurred: Steuben
Was 911 or local emergency number called? Yes
Time of Call: 12:15 AM
Did EMS respond to the scene? Yes
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
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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

LDSS Response

SCDSS received the SCR report, coordinated their response with LE, and notified the DA of the SC's death. LE informed SCDSS that they had already been to the home and conducted interviews with the family. LE stated that the SM informed

them that she had fed the child and placed her to sleep around 5:00 PM. The SM placed the SC on her stomach in the center of an adult bed and checked on her periodically. On top of the bed was a down comforter and pillows at the head. The SC was wearing a dress, a bib, a white cotton hat, and socks. At approximately 10:00 PM, the SM checked on the SC with the intention of feeding her and changing her diaper and found her cold to the touch and not breathing. The SM and SF attempted CPR before ceasing their efforts. The SF went and got the SM's uncle to tell him what happened. The uncle then later called 911 at 12:15 AM. LE did not believe there to have been any criminal intent to the SC's death and an autopsy would be performed on 5/8/2021. The LE investigation remained open at the time SCDSS closed their investigation, pending the results of the final autopsy report.

SCDSS interviewed the family in their home. The SM and the SF's recollection of the events was the same as what they had reported to law enforcement. SCDSS's investigation also revealed due to religious and cultural beliefs, the parents did not have a phone or have knowledge of available emergency medical services by calling 911. The father added he notified his uncle who lived next door of the incident and the uncle came to the house. The SF then went to the next house to tell the SM's uncle (MGU) what had happened, and he came to the home to be with them. The parents also denied having previous knowledge of safe sleep practices.

SCDSS interviewed the MGU in his home. The MGU stated that he did not know he should have called 911 sooner and was only informed he needed to call 911 when he spoke with the community's undertaker who informed him to call 911 so the coroner could pronounce the SC dead. This was corroborated by the undertaker through a collateral interview performed by SCDSS. The undertaker stated it was culturally appropriate to have little to no knowledge of emergency services or to contact 911 when a community member passed away.

An autopsy was performed by the ME. The ME's preliminary findings supported a cause of death consistent with an unsafe sleep environment. The final autopsy report had not been received by the time the investigation had closed.

SCDSS interviewed the midwife that delivered the SC and conducted her initial follow up appointments. There were no medical concerns identified for the SC by the midwife. The midwife stated that they educated all patients on safe sleep practices as it was common for members of the parent's community to place an infant to sleep on their stomach or side if they did not sleep well placed on their backs. When requested by SCDSS, the midwife did not provide documentation in their records that the SM and SF were specifically educated on safe sleep practices. SCDSS interviewed the pediatrician for the SSs. The pediatrician identified that they had provided no medical care to the SC, as it was common in the family's community for the midwife to provide initial follow up care for infants unless a concern for their health was identified. The pediatrician identified no medical concerns for the SSs or any historical concerns for their care by the SM or SF.

SCDSS conducted their investigation and made a determination to unsubstantiate the allegations of DOA/Fatality and Inadequate Guardianship against the SM and SF. The SSs were assessed as safe in the care of the SM and the SF. SCDSS offered the SM and SF services in relation to the death of the SC which were declined, citing the use of community resources.

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 reviewed by an OCFS approved Child Fatality Review Team?No

Comments: Steuben 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
058088 - Deceased Child, Female, 4 Month(s)	058089 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
058088 - Deceased Child, Female, 4 Month(s)	058089 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
058088 - Deceased Child, Female, 4 Month(s)	058090 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
058088 - Deceased Child, Female, 4 Month(s)	058090 - Father, Male, 24 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?	☐	☐	☒	☐

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:
Risk was assessed throughout the investigation. Services in relation to the death of the SC were offered and declined by the family.

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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

Additional Local District Comments

Steuben County DSS conducted a thorough investigation of this fatality. The Department found that the parents did not have information about safe sleep, found them credible as well as very insulated from general society where they may have come across this information during the raising of their three children. The family with their three children, as well as others in their community, practice placing babies to sleep on their stomach often and is considered a “normal practice” without issue. The child had no medical conditions. The child was clothed appropriately for the weather and indoor climate as noted in the report, the pictures and reports do not substantiate the clothing being near the child’s face which may have been a contributing factor. Furthermore the bed covering on which the child was placed was not fluffy but a thin fleece material blanket., another possible contributing factor. There were no aggravating circumstances as outlined in 10-OCFS-LCM-15 present that would suggest the parents acted without a minimum degree of care. Given the caseworker’s observations of the home, interviews of the family and collateral contacts, the parents exercised more than a minimum degree of care and did not maltreat this child. The Department finds this to be a fatality of which the parents do not have responsibility for and have exceeded the minimum degree of care based on normalcy for their culture, community, and family experience.

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