Child Fatality Report

Report Identification Number: BU-21-002

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

Issue Date: Jun 28, 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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 7 month(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 01/04/2021
Initial Date OCFS Notified: 01/04/2021

Presenting Information

An SCR report was received which stated that on 1/3/21 at 10:00PM, the mother placed the seven-month-old child to sleep in a portable crib, in the same room as the two-year-old sibling. At 3:33AM on 1/4/21, the mother went back into the room to check on the children and found the seven-month-old on the floor between the portable crib and a couch that was beside it. The mother picked the child up and brought him to the father in another room. The father began cardiopulmonary resuscitation while the mother called 911. The child was brought to the hospital via ambulance where he was pronounced deceased. He was an otherwise healthy child and the parents had no explanation for his death.

Executive Summary

This fatality report concerns the death of a seven-month-old male subject child that occurred on 1/4/21. A report was made to the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother and father. Niagara County Department of Social Services (NCDSS) received the report and investigated the child's death. An autopsy was completed; however, the final report had not yet been released at the time of this writing.

At the time of the child's death, he resided with his mother, father and five siblings, ages 2, 10, 12, 14 and 15 years old. The investigation revealed that in the early morning hours on the date of the child's death, the mother had fed the child and then placed him to sleep in a raised bassinet attached to the inside of a portable crib. The portable crib was located in the family room next to a couch. The mother then went into her and the father's bedroom to sleep. At approximately 3:30AM, the two-year-old sibling woke the mother asking for a drink and help using the bathroom. The mother assisted the sibling and also checked on the subject child. The mother found the child on the floor between the portable crib and the couch; he was limp and not breathing. The mother woke the father, who had been asleep in the bedroom. Emergency services were called, and the child was transported to the hospital via ambulance. The child could not be resuscitated and was pronounced deceased at 4:43 AM on 1/4/21.

From the time the investigation began to the time of its closure, NCDSS interviewed family members and collateral sources, which included hospital staff, the medical examiner, law enforcement and the child's pediatrician. The safety of the siblings was assessed and there were no concerns noted. Law enforcement found no criminality regarding the death of the child, and services were offered to the family in response to the fatality. The record noted the parents had been previously educated surrounding safe sleep practices. It was discovered the child had recently begun crawling and pulling himself up, and fell or climbed out of the portable crib, landing headfirst between the portable crib and the couch. The medical examiner informed NCDSS the child most likely died due to suffocation caused by wedging. The mother was aware the raised bassinet needed to be lowered because of the child's age and mobility; however, she failed to do so and continued placing the child to sleep in an unsafe environment. Therefore, NCDSS 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:
NCDSS gathered information to determine the allegations and assess the safety of the surviving 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: 01/04/2021 **Time of Death:** 04:43 AM

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

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? Yes
Time of Call: 03:33 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? 2 Hours
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	Male	7 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)

LDSS Response

On 1/4/21, NCDSS received the SCR report regarding the death of SC, which occurred on that same date. NCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. NCDSS learned there were 5 SSs and worked promptly to assess their safety.

On 1/4/21, NCDSS met with the family at their home. The parents were interviewed and explained the day prior to SC's death was a typical day where nothing out of the ordinary occurred. SM reported she last fed SC around 1:00AM the morning of the incident, and then placed SC on his back in a portable crib to sleep. SM reported the portable crib was in the family room next to the couch. Inside of the portable crib was an attached bassinet, and this was where SC slept. SM said after she laid SC down, she went into her and SF's room and went to bed; all of the SSs were asleep in their bedrooms and only SC was in the living room. SM reported around 3:30AM, the 2-year-old SS woke her up needing to use the bathroom and wanting a drink. SM said she got up to help SS, and then checked on SC. SM stated that is when she found SC on the floor next to the portable crib; she could not recall what position he was in. SM explained she picked SC up and he was limp and not breathing, but still warm. She brought SC into her and SF's bedroom and woke SF, who then began CPR. SM said she called 911. SF explained he had gone to bed around 10:30PM on 1/3/21, and was next awakened by SM after she had found SC. Both parents denied SC had been ill or acting differently in the days leading up to his death. They

explained SC had recently begun rolling over, pulling himself up, and crawling. SM reported the bassinet was located about 12" down into the portable crib, and she had been planning to lower it since SC was becoming more mobile, but never did. SM explained she delayed doing so because SF had recently had surgery and it was easier for him to pick up SC when the bassinet was in the higher position.

On this same date, NCDSS interviewed the SSs. None of the children witnessed what occurred aside from seeing first responders in the home. There were no safety concerns disclosed. The older SSs reported SC would sleep with SM on the couch or in the portable crib's bassinet.

NCDSS spoke with the ME who advised the parents' explanation of what occurred was plausible. The ME stated raised bassinets should not be used for children over 6 months old, and SM was aware of this. The ME further reported SC appeared well cared for and healthy; however, petechiae were observed on his face which was indicative of being wedged or “squished.”

From the time the investigation began to the time of its closure, NCDSS spoke with family members and collateral sources. Statements obtained by LE corroborated the information gathered by NCDSS. Medical staff concluded SC either climbed or fell out of the bassinet and landed headfirst in the gap between the portable crib and the couch, causing suffocation. There were no criminal charges brought against either parent, and NCDSS provided the parents with referrals for grief and bereavement services. NCDSS found evidence SM placed SC in an unsafe environment by putting him to sleep in a raised bassinet he had outgrown, and therefore, the allegations against SM were substantiated. SF was asleep at the time SM put SC in the bassinet the morning of the fatality, and there was no evidence his actions or inaction placed SC at risk of harm or contributed to SC's death. The allegations against SF were unsubstantiated, and the report was indicated and closed.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: From an injury - external cause
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 Niagara County multidisciplinary team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Niagara County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057322 - Deceased Child, Male, 7 Mons	057324 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
057322 - Deceased Child, Male, 7 Mons	057324 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
057322 - Deceased Child, Male, 7 Mons	057323 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated

057322 - Deceased Child, Male, 7 Mons	057323 - Mother, Female, 36 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:

NCDSS 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: NCDSS provided grief counseling referrals to the family and linked the parents with a behavioral health clinician.				

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 siblings were assessed as safe in the care of their parents.				

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:
Services were offered to the family in response to the child's death. NCDSS linked the parents to a behavioral health clinician, and the siblings were receiving additional support through their school social workers.

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:
Service referrals for grief and bereavement counseling were provided to the parents for the surviving siblings. The parents stated the siblings were also receiving counseling through their school.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Service referrals for grief and bereavement counseling were provided to the parents in response to the child's 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 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

The mother and father were named as subjects in one unfounded report from 2013 with allegations of Fractures, Inadequate Guardianship, Swelling/Dislocations/Sprains and Lacerations/Bruises/Welts regarding the now 10-year-old sibling.

Known CPS History Outside of NYS

There was no known CPS 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