



Report Identification Number: SY-20-048

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

Issue Date: Mar 29, 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: 3 month(s)

Jurisdiction: St. Lawrence
Gender: Female

Date of Death: 10/18/2020
Initial Date OCFS Notified: 10/19/2020

Presenting Information

St. Lawrence County Department of Social Services (SCDSS) received a report from the SCR which alleged the 3-month-old subject child was visiting her father's home when he placed her to sleep in his bed. The father placed the subject child to sleep on her back next to him in the same bed around 12AM. At 7:30AM on 10/18/20, the father woke to find the subject child unresponsive. The child was born with a collapsed right sinus cavity and the report alleged co-sleeping with the father contributed to her death.

Executive Summary

On 10/19/20, SCDSS received an SCR report regarding the death of the 3-month-old female subject child that occurred on 10/18/20. At the time of the child's death, she was visiting her father at his home. The subject child lived between her mother and father's home. There were no surviving siblings or other children residing in either home.

SCDSS conducted a joint investigation with law enforcement and they learned that the father had the subject child for parenting time from 10/17/20 through 10/18/20. The subject child spent time with the paternal grandmother while the father worked on 10/17/20. The father reported he picked the child up from the paternal grandmother and brought her to his home. The father fed the subject child and laid her down in bed next to him while he watched television. The subject child fell asleep while the father stayed up several hours watching a movie. The father reported he fell asleep sometime after 10PM. The father woke the next morning at approximately 7:50AM and realized the subject child had not woken at her regular feeding time of 4:30AM. The father discovered the child was not breathing and brought her to the paternal grandmother's home, which was located next door. The paternal aunt called 911 and CPR was administered at the direction of the operator until first responders arrived and took over efforts. The subject child was transported to the hospital but attempts to resuscitate her were unsuccessful and she was pronounced deceased at 9:13 AM.

An autopsy was performed, and the cause and manner of death was "undetermined." The autopsy report lists other significant conditions as "co-sleeping." The medical examiner reported that there were no signs of trauma, the toxicology test was negative, and the only notable abnormality had been a deviated septum. The medical examiner noted the subject child had disease involving her lungs. The lungs had severe congestion and edema. Law enforcement concluded their investigation with no criminal charges filed. The autopsy report did not reflect whether or not the deviated septum or lung issue contributed to the child's death.

SCDSS closed the investigation after substantiating the allegation of inadequate guardianship against the father. SCDSS determined the subject child was in immediate danger of serious harm due to the father's placement of the child in a co-sleeping environment. It appeared there were unused, safe alternative sleeping arrangements available in the home. SCDSS found the autopsy did not conclusively state that co-sleeping directly caused or contributed to the subject child's death, thus the DOA/fatality allegation was unsubstantiated. SCDSS provided the parents and grandparents with information on bereavement and mental health crisis services. After sufficient information was gathered and documented with respect to the fatality and the open investigation, SCDSS ended their involvement and closed the case.

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? 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:

Casework activity was commensurate with case circumstances.

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:

SCDSS indicated and closed the investigation once regulatory requirements were met.

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: 10/18/2020

Time of Death: Unknown

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

County where fatality incident occurred: St. Lawrence

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:

- | | | |
|--|----------------------------------|---|
| <input checked="" type="checkbox"/> Sleeping | <input type="checkbox"/> Working | <input type="checkbox"/> Driving / Vehicle occupant |
| <input type="checkbox"/> Playing | <input type="checkbox"/> Eating | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other | | |



Did child have supervision at time of incident leading to death? Yes

How long before incident was the child last seen by caretaker? 7 Hours

At time of incident supervisor was: Not impaired.

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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	20 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	18 Year(s)
Other Household 1	Grandparent	No Role	Female	41 Year(s)
Other Household 1	Mother	No Role	Female	20 Year(s)

LDSS Response

SCDSS initiated their investigation promptly by coordinating with LE and sharing information. In addition to LE, SCDSS contacted the source, hospital, district attorney, the parents, and the family members. SCDSS reviewed CPS history which revealed that neither the parents nor child were known to the system as confirmed subjects or recipients of services as adults. These actions were completed on the date of the SCR report, and further contact with the family and collaterals continued throughout the length of the investigation.

The parents resided in separate households. The mother resided at home with the maternal grandmother and maternal aunt. The father resided at his own home and had frequent parenting time with the subject child. SCDSS interviewed the maternal aunt, maternal grandmother, and paternal grandparents, no one expressed any concerns for the parents' care of the infant. After speaking with collaterals who interviewed the parents in response to the incident, as well as speaking with the parents and household members, SCDSS learned the father went to sleep with the child in his bed sometime after 10PM on 10/17/20. The father placed the subject child on her back in the bed next to him. He woke around 7:50AM and found the subject child not breathing. The father ran with the subject child to his parents' home, which was located next door, and his sister called 911. The paternal grandmother performed CPR on the subject child until first responders arrived and took over efforts.

The father provided a description of the sleeping arrangements. He stated that the bed did not have a headboard and that he propped pillows up against the wall and placed the subject child below them, on her back on the bed. He reported he had basic sheets and pillowcases and one comforter on his bed. He said the subject child was not covered by any blankets. There was a bassinet available for the subject child that was not being used. The father reported he often co-slept with the subject child. Both the mother and father were aware of safe sleep guidelines. The mother reported practicing safe sleep while the infant was in her care. The mother reported she did not have concerns for the child's safety in the care of the father.

The mother denied using drugs during pregnancy when asked by SCDSS. Both parents denied current substance use, and no signs of additional areas of child welfare concern were observed or revealed in the interviews. A police officer who was a first responder reported observing no concerns the father was under the influence of any substance. SCDSS facilitated



drug tests for both parents after the SCR report, and all results were negative. 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: Undetermined

Primary Cause of Death: Undetermined if injury or medical 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: SCDSS adhered to approved protocols for joint investigations by contacting the DA's office about the death and collaborating with law enforcement.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056302 - Deceased Child, Female, 3 Month(s)	056627 - Father, Male, 20 Year(s)	DOA / Fatality	Unsubstantiated
056302 - Deceased Child, Female, 3 Month(s)	056627 - Father, Male, 20 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

SCDSS contacted all relevant collateral sources.



Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:

SCDSS referred the family to mental health and bereavement counseling following the death.

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? N/A

Explain:

There were no siblings or other children residing in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

SCDSS provided referrals for bereavement and mental health 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