Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-21-018

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

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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: 6 year(s)
Jurisdiction: Steuben
Gender: Male
Date of Death: 07/19/2021
Initial Date OCFS Notified: 07/19/2021

Presenting Information

On 7/18/21, the subject child fell ten feet onto concrete while in the care of the mother and the father. The child was playing on top of a hay mound prior to falling. As a result, the child sustained a traumatic brain injury, pneumothorax, as well as, respiratory failure with hypoxia and was placed on life support. The parents were aware that the child was on the hay mound and were also aware of the unsafe conditions, however, they failed to intervene to protect the child. On 7/19/21, at 5:55AM, the child succumbed to the injuries sustained and passed away after he was taken off of life support.

Executive Summary

On 7/19/21, the Steuben County Department of Social Services (SCDSS) received an SCR report regarding the death of the 6-year-old subject child. The report was subsequent to an open CPS investigation that began on 7/18/21, which was in regard to the child becoming hospitalized after he fell from a hayloft while playing at his home. The child resided with his mother, father and five siblings, ages 10, 8, 3 and 2 years and a 9-month-old. The siblings were determined to be safe in the care of their parents.

Through a joint investigation with law enforcement, it was learned that on 7/18/21, the family had attended religious services and then gathered at their home to spend time with relatives and friends. The children were outside playing in a barn that was across from where the men were socializing. The women were inside preparing food. The adults periodically checked on the children, who were playing inside of a hay barn. Around 5:00PM, the 10-year-old sibling went to the father and told him the subject child had fallen while playing in the hay loft. The father ran to the hay barn and discovered the child laying on his back and minimally responsive. The father brought the child inside and then a family friend called 911. Emergency medical services responded and transported the child to the hospital via a helicopter. The child was placed on life support and his condition continued to worsen. The parents removed the child from life support and he passed away on 7/19/21.

An autopsy was not performed per the request of the parents. The death certificate was received and the manner of death was accidental and the cause was complication of blunt force injury of head. Law enforcement found no criminality related to the death and closed their investigation.

SCDSS unsubstantiated the allegations of DOA/Fatality, Inadequate Guardianship and Internal Injuries against the parents. SCDSS completed several extensive interviews regarding the fatal incident and received similar accounts about the event. It was determined on the day of the incident, the adults provided periodic supervision of the children and the subject child accidentally fell. SCDSS determined there was no evidence that maltreatment occurred and unfounded the report. The parents were provided information on grief counseling and funeral assistance. The CPS investigation was closed on 9/29/21.

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:
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 documented extensive and thorough efforts to gather information related to the allegations. An appropriate determination was made given the evidence obtained.

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: 07/19/2021 **Time of Death:** 05:55 AM

Date of fatal incident, if different than date of death: 07/18/2021
Time of fatal incident, if different than time of death: 05:00 PM

County where fatality incident occurred: Steuben
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? 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: **Socializing with friends**

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	6 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	33 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Month(s)

LDSS Response

SCDSS investigated the incident by searching SCR history and speaking to the source of the report, the mother, father and siblings. They made collateral contacts with neighbors, friends, family members, law enforcement, emergency medical services and the pediatrician.

The mother and father were interviewed and it was learned on the day of the fatal incident the community gathered at the family's home following religious services. This was typical for the community, and in attendance were neighbors, friends and family members. The children played, the men socialized in the shop, and the women socialized and prepared dinner in the house. The adults periodically checked on the children as they played. There was also a direct line of vision from the rear of the home to the barn door entry where the children were. The mother was in the home at the time of the incident and became aware of the injury when the father brought the child inside. The father was in the shop playing corn hole with friends when the 10yo SS came to get him. The father rushed to the SC. He shook the SC to try to get him to respond. The father brought the SC into the home so he would be more comfortable and then sent someone to call 911. The father reported to law enforcement that the children were not allowed to play in the hay loft.

SCDSS documented numerous collateral contacts. Members of the community reported the adults were checking on the

children periodically throughout the day. The women were inside preparing dinner when the father carried the SC into the home after he fell and placed him on the bed. There were no visible injuries to the SC, other than a small bruise on the left side of his forehead. They denied there was anything out of the ordinary and that the activities of the day were typical for Sundays. Another man who was present reported that the father immediately instructed him to call 911 after bringing the SC inside. The man ran approximately a quarter mile to a shed with a telephone and proceeded to call emergency medical services. There were no concerns reported for the parents' care of the SC and SSs during interviews with collaterals.

SCDSS interviewed the SSs who were of age to participate and the other children who were present at the time the SC fell. The 8-year-old sibling reported that they were playing "bag tag" in the loft and the SC was "it". The children got into the loft after an unrelated 11-year-old child retrieved the ladder and put it up for them. While playing the game, the SC was looking up in the haybales for someone to throw the bag at. He was walking backwards at the same time when he fell down the hay chute onto the concrete below. The 8yo SS stated he went down the ladder after the SC fell and the 10yo SS went to get their father, who came running to the hay barn immediately. The younger SSs were observed and determined to be safe with their parents. SCDSS observed the 9-month-old to have a safe sleep space and provided safe sleep guidance to the parents.

SCDSS gathered information from the pediatrician, hospital staff, first responders and law enforcement. Law enforcement arrived to the home and the SC had a heartbeat, but he required oxygen. Emergency medical services arrived and took over care of the SC. The SC was stabilized for transport via flight. The flight crew sedated the SC and performed rapid sequence intubation. First responders reported the parents were willing to comply with whatever medical treatment was needed. The SC arrived to the hospital with a severe traumatic brain injury with a poor prognosis. Despite maximal supportive efforts, the SC continued to decompensate, and the family decided to withdraw life support measures. The SC was pronounced dead at 5:55AM. The pediatrician reported no concerns for the family and stated that the children received medical care when they were sick.

Official Manner and Cause of Death

Official Manner: Accident
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

Was the fatality referred to 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
058661 - Deceased Child, Male, 6 Yrs	058663 - Father, Male, 33 Year(s)	DOA / Fatality	Unsubstantiated
058661 - Deceased Child, Male, 6 Yrs	058663 - Father, Male, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
058661 - Deceased Child, Male, 6 Yrs	058663 - Father, Male, 33 Year(s)	Internal Injuries	Unsubstantiated

058661 - Deceased Child, Male, 6 Yrs	058662 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
058661 - Deceased Child, Male, 6 Yrs	058662 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
058661 - Deceased Child, Male, 6 Yrs	058662 - Mother, Female, 31 Year(s)	Internal Injuries	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	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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:
The family was provided with information regarding grief counseling services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were provided with information regarding grief counseling and funeral assistance. The parents declined and elected to receive support through their community.

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

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 CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No