Child Fatality Report

Report Identification Number: BU-22-026

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 10/25/2022
Initial Date OCFS Notified: 10/25/2022

Presenting Information

On 10/22/22, the father laid the 4-month-old subject child face down on an unknown surface. The father left the area for approximately 15 minutes. When the father returned, the child was not breathing and he called 911. The child was transported to the hospital and placed on life support. On 10/24/22, an examination of the child revealed that he had bilateral retinal hemorrhages. The father had no explanation for how the child sustained the injuries. On 10/25/22, the child was pronounced deceased at 10:27AM.

Executive Summary

This fatality report concerns the death of a 4-month-old male child that occurred on 10/25/22. The child was listed on an open CPS investigation at the time of his death. The investigation began on 10/23/22 after an SCR report was received with concerns that the father placed the child in an unsafe sleep environment, and discovered him unresponsive 15 to 20 minutes later. The child was hospitalized and placed on life support. The child died on 10/25/22, and a report was made to the SCR with allegations of Inadequate Guardianship, Internal Injuries, and DOA/Fatality against the father.

Erie County Department of Social Services (ECDSS) learned of the incident regarding the subject child and immediately began gathering information. The subject child resided with his mother, father, and two siblings, ages 4 and 2 years old. The mother worked outside of the home and the father was the primary caretaker for the children. On the day of the incident, the mother left for work in the morning. The child woke between 7:00 and 7:30AM, and the father retrieved him from his bassinet. The child fell back to sleep in the father's arms and the father placed him in the middle of the parents' bed. The father placed the child on his stomach, pushed the blankets near the wall, and a placed pillow on the edge of the bed. The father went to make breakfast and when he returned 15 to 20 minutes later, the child was in the same position the father left him and was not breathing. The father called 911 and they instructed him on how to perform cardiopulmonary resuscitation. Emergency medical services arrived and transported the child to the hospital.

The subject child was initially received by one hospital but was then transferred to another, where he was admitted to the intensive care unit and placed on life support. ECDSS regularly inquired with hospital staff regarding the medical status of the subject child. Upon admittance, the child's prognosis was poor and he was not expected to survive. The ophthalmology department assessed the child and the findings were that the child had multiple retinal hemorrhages in both eyes. Two brain death tests were conducted and determined the child had no brain activity. The child was removed from life support and died on 10/25/22. Due to the undetermined cause of the retinal hemorrhages, ECDSS implemented a safety plan, which required family members to supervise contact between the parents and siblings, until additional information could be obtained from the medical examiner.

An autopsy was completed and the final results were pending at the time the CPS investigation was closed. ECDSS gathered information from the medical examiner's office regarding the preliminary findings. There was no evidence of trauma and the child appeared well cared for. The father's explanation of the child being found face down was consistent with the death. The death appeared to be an asphyxiate incident, where the child suffocated; therefore, the brain was swollen, resulting in bilateral retinal hemorrhages. Due to this information, ECDSS terminated the safety plan.

ECDSS offered grief counseling, mental health and crisis counseling, provided information community-based services, and made a referral to early intervention. Based on the preliminary findings from the medical examiner and information about how the child was placed to sleep, ECDSS determined there was a fair preponderance of evidence to substantiate

the allegations of Internal Injuries, Inadequate Guardianship and DOA/Fatality against the father. The investigation was indicated and closed on 12/6/22.

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:
ECDSS made an appropriate determination given the information gathered.

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:
Casework activity was commensurate with 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: 10/25/2022 **Time of Death:** 10:27 AM

Date of fatal incident, if different than date of death: 10/22/2022
Time of fatal incident, if different than time of death: 08:15 AM

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 08:19 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ 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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

Within the first 24 hours of the investigation, ECDSS contacted the source of the report, notified the medical examiner and district attorney's offices of the death, documented a CPS history check, interviewed medical collaterals and assessed the safety of the SSs.

ECDSS interviewed the father, who reported that on the day of the incident, he was home with the child and siblings after the mother left for work. Between 7:00 and 7:30AM, the child woke up and the father retrieved him from the bassinet. The child was face down in the bassinet and the father picked him up and held him until he fell back to sleep. The father placed the child face down in the middle of the parents' bed. The father moved the blankets to one side and placed a pillow at the edge to prevent the child from rolling off. The child was swaddled, with his arms inside of the swaddle. The father stated the child's face was to the side. The father reported that though the child typically slept in a bassinet, it was routine for him to place the child to nap in the bed during the morning hours. The parents reported when they placed the child to sleep on his back, they would find that he had rolled onto his stomach. The father made breakfast and checked on the child 10 to 15 minutes later. The child was in the same position but did not appear to be breathing. The father rolled him over and listened to his chest. When he did not hear anything, the father called 911 and performed CPR at the instruction of 911 dispatch.

ECDSS interviewed the mother, who reported the morning of 10/22/22, the child woke her up at 5:00AM. The mother breastfed the child, burped and rocked him, then left for work around 5:30AM. Prior to leaving, the mother placed the child on his back in the bassinet. The surviving siblings were interviewed and disclosed no concerns. At initial home visits, the 4yo sibling reported the father killed the child with a pillow. The father denied this, and the parents explained that the sibling had been hearing pieces of the story and explaining the child's death in this manner. The 4yo denied seeing the father do anything to the child with a pillow. The surviving siblings were medically assessed, including a skeletal exam for the 2yo sibling, and there were no abnormal findings.

ECDSS gathered information from medical collaterals regarding their findings related to the subject child's death. There was no history of accidental trauma provided that could explain the child's intracranial findings and retinal hemorrhages. It was determined that the child was developmentally normal, could roll over, and had expected upper body and neck strength. The child was face down on the bed and his arms were swaddled and could not help him adjust his position. Unsafe sleep was a possible cause of his condition. Based on the child's retinal hemorrhages, non-accidental trauma could not be ruled out, though it was noted the characteristics of the child's retinal hemorrhages were not diagnostic of abuse. The children's pediatrician reported no concerns for the child or siblings' care.

Law enforcement reported that there would be no homicide charges against the father due to the medical examiner's preliminary findings. ECDSS consulted with their legal department, and it was determined a neglect petition would not be filed in family court. The family was provided with information on community-based services.

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 referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The record reflected that the fatality would be referred to Erie County's OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062834 - Deceased Child, Male, 4 Mons	062836 - Father, Male, 37 Year(s)	DOA / Fatality	Substantiated
062834 - Deceased Child, Male, 4 Mons	062836 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
062834 - Deceased Child, Male, 4 Mons	062836 - Father, Male, 37 Year(s)	Internal Injuries	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?	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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 parents were provided information on community-based services on behalf of the siblings.

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 grief counseling, mental health counseling and information on community-based services.

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
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs
☐ Used prescription drugs
☒ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none 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 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.

Additional Local District Comments

We at the Erie County Department of Social Services appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality

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