Child Fatality Report

Report Identification Number: BU-22-029

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

Issue Date: Apr 18, 2023

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: 10/31/2022
Initial Date OCFS Notified: 10/31/2022

Presenting Information

An SCR reported alleged on 10/31/22, at approximately 3:00 AM, the 4-month-old child fussed and cried. The father tended to the child and once he was consoled, the child was placed into his crib. The position in which the child was placed or if the crib contained items was unknown. When the parents checked on the child in the morning, the child was unresponsive, cold, and rigor mortis had set in. The mother called EMS, who responded, performed CPR, and transported the child to the hospital. The child was administered medication but did not respond and was pronounced deceased at 8:52 AM. Although the child was born prematurely and had narrowing of his pulmonary valve, he was otherwise healthy. The parents could not explain the death.

Executive Summary

This fatality report concerns the death of a 4-month-old child that occurred on 10/31/22. A report was made to the SCR on the same day alleging the child was found unresponsive and not breathing after being placed to sleep in a portable crib. Subsequently, the child died. At the time of the child's death, he resided with his parents, twin sibling, and older siblings, aged 7 and 9 years. The siblings were assessed to be safe in the care of the parents.

Erie County Department of Social Services (ECDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The outcome of the criminal investigation remained unknown. An autopsy was performed but the final report had not yet been received at the time this report was written. Staff from the medical examiner's office reported there was no trauma to the child and that the death appeared to be a result of an unsafe sleeping environment.

The parents were interviewed and reported the child appeared normal on the day prior to his death. During the night, the father tended to the child as he was fussy. The father placed the child on his chest and laid on the couch. When the child stopped crying, the father placed the child in his crib, on top of a u-shaped pillow. Around 7:30 AM, the father discovered the child unresponsive and not breathing. The mother called 911 and the child was transported to the hospital, where he was pronounced deceased. The older siblings did not have additional information.

ECDSS made collateral contacts with hospital staff, the pediatrician, a visiting nurse and two adults with unknown relationships with the parents. The only concern for the children's safety was that the parents were placing the twins in unsafe sleeping environments.

The record did not reflect ECDSS attempted to gather information from the family's state of origin after learning that the older siblings had historically been in Foster Care.

ECDSS substantiated the allegations of Inadequate Guardianship and DOA/Fatality against the parents. The Investigation Conclusion Narrative stated the parents failed to exercise a minimum degree of care which resulted in the death of the child. The investigation revealed the father held the child on his chest and that the child fell under the father's underarm yet was breathing at that time. The father was laying on the couch and had his eyes closed. The visiting nurse stated she believed the parents regularly co-slept with the child. However, it remained unknown what made the nurse believe the parents co-slept.

The parents were offered bereavement services and burial assistance. It remained unknown if the family utilized the services. The case was closed on 01/10/23.

PIP Requirement
ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the ECDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ECDSS 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?** Yes

Explain:
The allegations were appropriately determined.

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:
Casework activity was not commensurate with case circumstances as ECDSS did not document an attempt to obtain out of state child welfare records.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Although the mother stated the older siblings were in Foster Care in the past, the record did not reflect ECDSS attempted to gather information about child welfare history from their state of origin.

Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ECDSS will make diligent efforts to contact collaterals to potentially gather outside information.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/31/2022 **Time of Death:** 08:52 AM

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

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 06:24 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Month(s)

LDSS Response

On 10/31/22, ECDSS received the fatality report from the SCR. 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, and coordinated with law enforcement. The siblings were assessed to be safe with the parents.

A law enforcement officer said there was no trauma to the child and that the medical examiner reported the child fell asleep on the father's chest and then the father placed the child in a portable crib with a u-shaped pillow. The parents woke around 7:30 AM and the child was unresponsive.

On 10/31/22, a home visit was made and there were adults in the home; the relationship with the family remained unknown. The parents were not home at the time. The adults reported that the mother called one of them to say the child was found unresponsive and not breathing. They reported the child was discovered face down in his crib.

ECDSS returned to the home on the same day to interview the family. The parents said the child fussed and cried around 3:00 AM and the father consoled him. The father laid on the couch, with the child face down on the father's chest. The father closed his eyes. The mother reported seeing the father laying on the couch awake before she went to bed. The father denied falling asleep and stated, "I may have been careless." He said that the child had slipped close to the back of the couch and had slid into the father's underarm. The father stated the child was breathing when he placed him to sleep in the crib. The child was swaddled and placed face up on a u-shaped pillow. The parents stated that doctors and nurses advised this was acceptable as it aided in the reduction of acid reflux. When the father found the child unresponsive, he alerted the mother, who called 911. The father attempted to perform CPR until first responders arrived and took over resuscitation efforts. The siblings stated they were told to stay in their rooms, and the 7-year-old sibling knew the child stopped breathing while he was in his crib.

ECDSS contacted hospital staff and the pediatrician. Hospital staff said the parents received safe sleep education when the child and his twin were in the hospital. The pediatric nurse stated there was nothing in the child's chart that reflected the parents were told to prop the children on pillows. A visiting nurse said she believed the parents co-slept regularly as she had been in the home and observed the child to be on the bed. She denied other concerns.

ECDSS determined and closed the investigation after gathering enough information to determine the allegations and assess the safety of the surviving siblings. It was determined the family did not need further CPS intervention.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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 death was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063028 - Deceased Child, Male, 4 Mons	063031 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
063028 - Deceased Child, Male, 4 Mons	063031 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated

063028 - Deceased Child, Male, 4 Mons	063032 - Father, Male, 23 Year(s)	DOA / Fatality	Substantiated
063028 - Deceased Child, Male, 4 Mons	063032 - Father, Male, 23 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?	☒	☐	☐	☐

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?	☐	☒	☐	☐
Explain as necessary: The siblings did not need to be removed as a result of the fatality investigaiton.				

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:
The parents were offered a domestic violence referral as the family reported there was an incident prior to the death when the parents argued and then hit one another.

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? Unable to Determine
Explain:
The parents were provided bereavement referrals for the siblings; it remained unknown if they utilized the service.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
The parents were referred to grief counseling and domestic violence advocacy and they were offered burial assistance. It remained unknown if the services were utilized.

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? Yes
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/28/2019	Sibling, Male, 4 Years	Other Adult - Mother's then partner , Male, 27 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 6 Years	Other Adult - Mother's then partner , Male, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged on 11/28/19, before 3:10 AM, the mother's then partner (then alleged father of the older siblings) assaulted her while the siblings were present. The children did not sustain injuries. The partner was not intoxicated at the time of the incident. It was unknown if the partner had a history of violence.

Report Determination: Unfounded **Date of Determination:** 04/13/2020

Basis for Determination:
The Investigation Conclusion Narrative stated the mother denied being attacked by her then partner. The partner resided out of state. The mother said she was assaulted by another individual, while the children were sleeping in their rooms. That person fled the home before law enforcement officers arrived. The children denied hearing or seeing any fighting.

OCFS Review Results:
The investigation was initiated timely, and a CPS history check was completed. Home visits were made, and the family was interviewed. Attempts were made to contact the mother's then partner. Collateral contacts were made.

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

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

Although the mother and sibling reported the older siblings were in Foster Care, the record did not reflect ECDSS attempted to gather information regarding the family's CPS involvement from their state of origin.

Preventive Services History

03/16/20- 08/11/20 A Preventive Services Case was opened as the family had moved to Erie County from out of state and the eldest siblings had behavioral outbursts at school and the mother did not seem to understand the concerns. The mother disclosed that she had a developmental disability which affected her ability to anticipate, understand and solve problems. The mother was visually impaired and was struggling to find affordable housing. The mother became employed and was able to provide for the children. The mother adapted to the area, engaged in mental health counseling, and was linked with

services for her disability. The mother learned skills to assist the siblings in improving their behavior. The case was closed as the family had reached their goals and no longer accepted services.

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 (ECDSS) 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 CPS investigation conducted during the three years preceding the fatality was conducted appropriately and that there were no required actions vis-à-vis said investigation. With respect to the required action related to the fatality investigation, we must unfortunately concur that ECDSS failed to make efforts to gather information from a relevant collateral source in that no effort was documented to contact another state regarding known child welfare history from that state. While the gathering of appropriate information from collateral contacts is part of a consolidated Program Improvement Plan (PIP) currently being reviewed and addressed with the assistance and support of the Buffalo Regional Office of OCFS, the specifics of this citation will also be addressed with the investigating caseworker and the supervisor who conducted and oversaw the fatality investigation.

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