Child Fatality Report

Report Identification Number: BU-22-037

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

Issue Date: Jun 21, 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: Female
Date of Death: 12/26/2022
Initial Date OCFS Notified: 12/26/2022

Presenting Information

An SCR report alleged at 10:00 PM on 12/25/22, the SM fed the 4-month-old SC and placed her down to sleep in a DockATot inside a bassinet after she swaddled the SC in a blanket as the family lost power to their home. When the parents woke up at 8:30 AM on 12/26/22, the SM found the SC unresponsive and not breathing. The SM performed CPR while the SF called 911. LE and EMS responded to the home and took over resuscitation efforts. The SC was taken to the hospital and was pronounced deceased. There were no signs of trauma, but the SC's abdomen was swollen. The parents did not have an explanation for the death. There was old food and dirty dishes in the kitchen, making the home unsanitary for the 2-year-old SS. There was dirty laundry and clutter about the home. A subsequent report received on 1/3/23 alleged the home was dirty, the parents used marijuana and there was ongoing domestic violence of screaming and fighting in the presence of the SS. The home had a flea infestation.

Executive Summary

This fatality report concerns the death of the 4-month-old subject child that occurred on 12/26/22. A report was made to the SCR on the same day alleging the mother swaddled the child in a blanket and placed her to sleep in a DockATot inside of a bassinet. On 12/26/22 at 8:30 AM, the mother woke to find the child unresponsive and not breathing. The child died and the parents did not have an explanation for the death. On 1/3/23, a subsequent report was made to the SCR alleging the home was dirty with rotten food and had a flea infestation which created a health concern for the 2-year-old sibling. The report also alleged the parents used marijuana, screamed and fought in the presence of the sibling. At the time of the child's death, she resided with her parents and sibling. The sibling was assessed to be safe in the care of the maternal great-grandmother and the parents.

Erie County Department of Social Services (ECDSS) coordinated investigative efforts with law enforcement as well as Genesee County Department of Social Services. Genesee County Department of Social Services was involved in the investigation as the family was staying with the maternal great-grandmother following the death. At the time this report was written, the criminal investigation remained pending. An autopsy was performed, and the final autopsy report was not yet available at the time of this writing. The preliminary autopsy showed the child had a fractured skull.

The parents were interviewed and stated the mother swaddled the child in a blanket and placed her inside a DockATot, which was inside of a bassinet. The investigation revealed in the time leading up to the fatal incident, the family did not have power due to a blizzard, and that the home was cold. In the morning, the mother discovered the child unresponsive and not breathing. The father called 911 and the child was transported to the hospital where she was pronounced deceased.

ECDSS made collateral contacts including the maternal great-grandmother, a great-aunt, hospital staff, and first responders. The hospital doctor expressed concern for the child's fractured skull and presumed the parents did not seek medical attention for the child. The doctor questioned whether the child had been dropped, wiggled off furniture and landed on the floor, or if the fracture occurred during the birth.

Although law enforcement asked ECDSS not to discuss the fracture with the parents, the record did not reflect that the parents were explicitly asked whether the child was ever dropped or fell. At the time of case closure, it remained unknown how the child sustained a skull fracture.

ECDSS created a safety plan with the family that the sibling would not be unsupervised with the parents. The

great-grandmother agreed to provide supervision. It remained unclear when the safety plan was discontinued. ECDSS completed Safety Assessments and required reports timely. Home visits were made, and the safety of the sibling was continuously assessed. Services in response to the death were offered to the family; however, it remained unknown if they utilized the services.

ECDSS unsubstantiated the allegations of IF/C/S, PD/AM and DOA/Fatality. The investigation revealed the home was in disarray due to the power outage and the family was unable to wash clothes or dishes. The parents denied using drugs or that there was physical violence between them. There were no fleas in the home. The allegation of IG was inappropriately unsubstantiated. A supervisory note reflected "that the death of the child appears to be related to an unsafe sleep environment" as there were extenuating circumstances due to a blizzard and the home did not have heat; therefore, the parents placed the child in an unsafe sleeping environment in attempt to keep her warm; however, the Investigation Conclusion Narrative reflected the parents put the child to bed on the evening of 12/25/22 around 10:00 PM and the power had previously been restored around 6:00 PM the same day.

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?** No

Explain:
The decision to close the case was appropriate.

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 was not commensurate with case circumstances as the allegation of Inadequate Guardianship regarding the child was inappropriately determined.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ECDSS documented the child was placed in an unsafe sleeping environment with aggravating factors including a blanket and DockATot, yet the allegation of Inadequate Guardianship was unsubstantiated.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ECDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Buffalo Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/26/2022 **Time of Death:** Unknown

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: Unknown
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	Female	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

On 12/26/22, ECDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, ECDSS contacted the source of the report and notified law enforcement and the district attorney's office of the death. A CPS history check was completed and found no prior history. At the time of the death, the child resided with her parents and 2-year-old sibling. The sibling was assessed to be safe.

A law enforcement officer reported the parents put the child to sleep in a bassinet at around 10:00 PM on 12/25/22. The officer saw a DockATot inside of the bassinet. The child was wrapped in a blanket due to the home being cold as the family lost power. The parents woke around 8:30 AM to feed the child and found her unresponsive. The mother called 911.

On 12/26/22, the parents were contacted via phone. The mother said the home was in disarray due to the snowstorm disconnecting the power from their home and they were unable to do laundry or wash dishes. The mother reported that the child was wrapped in blankets as it was approximately 60 degrees in the home. The child was placed inside of a DockATot which was placed inside of her bassinet. In the morning, the mother found the child unresponsive, put her on the floor and began CPR. The parents denied normally wrapping the child in blankets or using a DockATot. The sibling was virtually assessed to be safe with the parents.

The maternal great-grandmother did not have concerns for the care the parents provided to the children. She said she tried to help the parents stay at her house due to the power outage but was unsuccessful as there was a travel ban due to the snowstorm.

ECDSS coordinated investigative efforts with Genesee County as the family were able to relocate to the great-grandmother's home following the death. Genesee County went to the great-grandmother's home and interviewed the parents. The parents reported that the mother breastfed the child and then put her down to sleep. The mother woke in the morning and found the child unresponsive. The mother was consistent with her recollection that she reported over the phone. The parents denied getting angry with the child and stated they would not hurt her.

Information was gathered from the medical examiner's office which noted the child had a 3" nondisplaced linear skull fracture of the left parietal bone extending from the sagittal squamosal suture. It was unknown if the child was dropped accidentally or if the injury was inflicted. A timeframe for when the child sustained the injury remained unknown. The medical examiner's office said that it was unclear if the fracture was related to the cause of death, and that the fracture was concerning. It was documented the medical examiner would report any suspicion regarding the death.

The family was offered appropriate services in response to the death and after all casework activity was completed, the investigation was determined and closed.

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
063574 - Deceased Child, Female, 4 Mons	063576 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
063574 - Deceased Child, Female, 4 Mons	063577 - Father, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated
063574 - Deceased Child, Female, 4 Mons	063576 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
063574 - Deceased Child, Female, 4 Mons	063577 - Father, Male, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
063575 - Sibling, Male, 2 Year(s)	063576 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
063575 - Sibling, Male, 2 Year(s)	063577 - Father, Male, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
063575 - Sibling, Male, 2 Year(s)	063576 - Mother, Female, 21 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
063575 - Sibling, Male, 2 Year(s)	063577 - Father, Male, 21 Year(s)	Parents Drug / Alcohol Misuse	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	☒	☐	☐	☐
Explain: The family was offered appropriate services in response to the fatality.				

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 sibling did not need to be removed as a result of the 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The family accepted bereavement services and funeral assistance; however, it remained unknown whether they utilized the services. The maternal great-grandmother was utilized as a safety plan for the sibling.

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? No
Explain:
The record did not reflect the sibling was referred for services in response to the death; however, due to his age, a referral was not required.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were referred for crisis services, mental health and bereavement counseling services and burial assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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 New York.

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

ECDSS strongly disagrees that INGD was inappropriately unsubstantiated. Per OCFS, "ECDSS documented the child was placed in an unsafe sleeping environment with aggravating factors including a blanket and DockATot" and a "supervisory note reflected 'that the death of the child appears to be related to an unsafe sleep environment' as there were extenuating circumstances due to a blizzard and the home did not have heat… however, the [record] reflected the parents put the child to bed… around 10:00 PM and the power had previously been restored around 6:00 PM." The record reflects the home had power when the child was put to bed, but equating power with heat is NOT reflected in the record. The record clearly reflects the home was approx. 60 degrees when the parents put the child to bed, and they attempted to keep the child warm in response; it also clearly reflects the parents did not normally use a DockATot or blankets in the bassinet but, because of the 60-degree home, they did use said items. Their actions were an atypical response to a very atypical and tragic situation; indeed, it would have been concerning had the parents NOT taken actions to ensure their child's warmth in the circumstances. Also, the phrase "appears to be related" is a correlational not causal statement, and the evidence in the record does not meet the fair preponderance of evidence standard needed to substantiate an allegation. Finally, per OCFS, "the record did not reflect that the parents were explicitly asked whether the child was ever dropped or fell." While the Genesee County worker did not ask this directly, the worker did ask the parents if they ever did anything they should not have done with regard to the child. It is supposed the parents would mention a drop or fall in response, had it occurred, yet the parents said no. OCFS also stated, "It was unknown if the child was dropped accidentally or if the injury was inflicted," without noting the possibility the injury occurred during birth.

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