



Report Identification Number: BU-19-025

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

Issue Date: Nov 14, 2019

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		



Case Information

Report Type: Child Deceased
Age: 1 month(s)

Jurisdiction: Erie
Gender: Female

Date of Death: 07/02/2019
Initial Date OCFS Notified: 07/02/2019

Presenting Information

Erie County Department of Social Services (ECDSS) received an SCR report on 7/2/19, which alleged that on either the night of 7/1/19, or the morning of 7/2/19, the mother went to sleep on a couch with her 2-month-old child. At some point between when she fell asleep and 8:36AM, the child expired due to cardiac arrest. The child was an otherwise healthy child.

Executive Summary

On 7/2/2019, Erie County Department of Social Services (ECDSS) received a report from the SCR about the death of a two-month-old child that occurred on the same date. The deceased child was the only child for both parents and no other children lived in the home.

Through interviews, it was learned on 7/2/19 at approximately 2-3AM, the infant was restless and fussy. The mother had been feeding the infant regularly so she wanted the infant near her at night. The mother gave conflicting accounts of the event to LE and ECDSS. Mother told LE she found the infant face down and wedged between the couch cushions and the back of the couch. The mother reported to ECDSS that the infant was leaned up against the mother's arm with a blanket pulled up to her chest and that was the position she was found in. The mother awoke and immediately called 911 and began CPR at the direction of the operator. First responders arrived and found the infant to be unresponsive. Resuscitation efforts were in process and the infant was transported to St. Joseph's Hospital in Cheektowaga. The infant was pronounced dead by the hospital physician immediately upon her arrival.

Throughout the investigation, ECDSS made extensive efforts to interview each first responder and diligently documented all casework. ECDSS spoke with all familial collateral contacts and medical personnel. ECDSS requested and reviewed all pertinent medical records for the deceased infant and submitted said records to OCFS for review. ECDSS discussed grief counseling, and other available resources with the family.

The preliminary autopsy findings were received by ECDSS. The ME reported the death was consistent with unsafe sleep as the infant had anterior lividity, which was consistent with the child being face down. LE investigated the fatality, but no criminal charges were pursued.

ECDSS appropriately indicated the allegations following a thorough investigation. ECDSS found there was credible evidence that the parents' negligence led to the infant's death. The mother and father failed to exercise a minimum degree of care for the infant when they placed her in an unsafe sleeping environment despite knowledge of safe sleep practice.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**



○ Safety assessment due at the time of determination? Yes

Determination:

- Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation? Yes, sufficient information was gathered to determine all allegations.
- Was the determination made by the district to unfound or indicate appropriate? Yes

Explain:

ECSSS appropriately indicated the allegations following a thorough investigation. All casework activities and decisions were appropriate and documented in a timely manner.

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:

The decision to close the case was appropriate, and there was documentation of supervisory consultation throughout the case record.

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: 07/02/2019

Time of Death: 08:55 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: 08:36 AM

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? No

Child's activity at time of incident:

- Sleeping
- Working
- Driving / Vehicle occupant
- Playing
- Eating
- Unknown
- Other

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



How long before incident was the child last seen by caretaker? 6 Hours

At time of incident supervisor was:

- Drug Impaired
- Alcohol Impaired
- Distracted
- Impaired by disability
- Absent
- Asleep
- Impaired by illness
- 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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

ECDSS received the report from the SCR on 7/2/19 and coordinated with LE, reviewed the CPS history, and notified the DA's office about the death. Throughout the investigation, collateral contacts were made with the source of the report, personal collaterals for the family, first responders, and various service providers.

Through interviews, it was learned on 7/1/19, the father arrived home from work at 5PM. The family watched television and fell asleep on the couch. Around 2AM the father awoke and found the mother feeding the infant. The father went into the bedroom and fell asleep around 3AM while the mother stayed on the couch with the infant. The father said the infant did not cry at all throughout the night, which was abnormal. The father woke at 8:30AM to the mother screaming that the infant was not breathing. The father immediately called 911. The father reported that the infant had a portable bassinet that was set up next to the bed, but it was not uncommon for the mother and child to fall asleep on the couch.

The mother was interviewed and gave the same account of events as the father. The mother said the infant had been eating more than normal and the mother believed she was having a growth spurt. For this reason, the mother slept on the couch with the infant so she was close to her. The information the mother provided to ECDSS was that the child was placed on her back on the couch with a blanket up to her chest. The mother said she found her in the same position when she woke and that she was unresponsive at that point. The mother did not corroborate the story with LE. The mother told LE she placed the infant between the cushion and the back of the couch and found the infant wedged between the two when she woke.

The mother reported having a full-term pregnancy with the infant. The mother used a prescribed medication during pregnancy, which the infant tested positive for at birth. The mother had a vaginal delivery with no complications. The mother's medical OBGYN records reflect that safe sleep education was discussed at length.

In response to the fatality, ECDSS accurately determined the allegations after conducting a thorough investigation. The safety and risk assessments were fitting to the case circumstances. ECDSS provided the family with a multitude of community based services, but it is unknown if these services were utilized. They concluded their involvement at an appropriate time when all necessary information was gathered and services were offered.



Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Unknown

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 reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051109 - Deceased Child, Female, 1 Mons	051111 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
051109 - Deceased Child, Female, 1 Mons	051110 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated
051109 - Deceased Child, Female, 1 Mons	051110 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
051109 - Deceased Child, Female, 1 Mons	051111 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities



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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other, specify: CAC for a family advocate

Additional information, if necessary:

ECDSS provided the family with a multitude of community based resources. ECDSS gave the family referrals for bereavement services as well as information on programs that could assist with funeral arrangements. Additionally, ECDSS referred the parents to the CAC for a family advocate that could assist with the grieving process and offer referrals and support.



Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A

Explain:

No service needs were identified as there were no siblings or other children in the home.

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 a plethora of information on fatality-related services. The parents identified grief services could have been beneficial, though it was unknown whether any services were utilized while the case was open.

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? N/A
- Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- Had medical complications / infections
- Misused over-the-counter or prescription drugs
- Experienced domestic violence
- Was not noted in the case record to have any of the issues listed
- Had heavy alcohol use
- Smoked tobacco
- Used illicit drugs

Infant was born:

- Drug exposed
- With fetal alcohol effects or syndrome
- With neither 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 is no history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known 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

In response to the Child Fatality Report that OCFS posted on October 28, 2019 with respect to a report made to the New York Statewide Central Register of Child Abuse and Maltreatment involving the death of a child, Erie County Department of Social Services (ECDSS) had the following response:

We at Erie County Department of Social Services (ECDSS) appreciate the opportunity given us to review the draft report in advance. We find 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 were no required actions related to the fatality.

Again, we thank you for allowing us the opportunity to review DRAFT NYS OCFS Child Fatality Report BU-19-025.

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