Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-22-016

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

Issue Date: Jan 03, 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 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	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: 07/28/2022
Initial Date OCFS Notified: 07/28/2022

Presenting Information

An SCR report alleged that on 7/27/22 at 10:30PM, the mother and the aunt slept in the same bed with the 4-month-old male subject child. On 7/28/22 at approximately 8:20AM, the mother woke up and found the child unresponsive. He was cold and stiff, and in a state of rigor. There was a pooling of blood near the child and the sheets were blood soaked. The mother called 911 and law enforcement arrived to the residence at approximately 8:25AM. The child was pronounced dead at the home. It was alleged the unsafe sleep situation contributed to the child's death. A subsequent report was received on the same day and alleged the same information as the initial report.

Executive Summary

On 7/28/22, Erie County Department of Social Services (ECDSS) received two SCR report regarding the death of the 4-month-old male child that occurred on the same day. The report alleged DOA/Fatality and Inadequate Guardianship against the mother and aunt of the child. At the time of the death, the mother and child were homeless and temporarily staying with the aunt, the aunt's parents, and an unrelated 16-year-old child. Upon receipt of the SCR reports, ECDSS assessed the safety of the 16-year-old and determined there were no concerns.

Throughout the investigation, ECDSS gathered information from collateral sources, the mother, and the aunt. On the evening of 7/27/22, the mother was at the aunt's home with the subject child. The mother bathed and fed the child and once he fell asleep, she placed him down horizontally across the bed. The aunt returned home from work around 11:15PM, and laid down on the other side of the child and went to sleep. The mother stayed awake and heard the child began to fuss around 2:30AM. The mother fed the child, and the child went back to sleep. The mother fell asleep afterwards with the child between her and the aunt. At approximately 8:00AM, the aunt alerted the mother that the child was cold to the touch and did not appear well. The mother picked up the child and discovered he was unresponsive. The aunt called 911 and the mother and aunt performed cardiopulmonary resuscitation until first responders arrived. First responders determined the child had been deceased for a few hours and he was not transported to the hospital.

An autopsy was conducted and the Medical Examiner reported there was nothing in the preliminary review that indicated abuse or neglect of the child. No other information was provided and the final cause and manner were pending. Law enforcement did not intend to pursue criminal charges regarding the fatality. The criminal investigation remained open pending the results of the toxicology and law enforcement reported they would notify ECDSS if anything abnormal returned.

ECDSS unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the aunt regarding the child, as they determined the aunt did not regularly care for the child, and was not a person legally responsible for the child. The aunt reported the mother and child were only staying at her home for a few days. Inadequate Guardianship and DOA/Fatality was substantiated against the mother regarding the child. It was determined the mother was educated on safe sleep practices, and despite this placed the child in an unsafe sleep environment in which he was discovered deceased.

ECDSS attempted contact with the subject child's father, and were unable to interview him prior to the closure of the investigation. The father had two other children, ages 4 and 3, who resided with their mothers. ECDSS documented in a case conference that the mother, child and father had no contact with the 3-year-old sibling. There was no discussion regarding the contact the father or subject child had with the 4-year-old sibling. Following the child's death, the mother was no longer staying with the aunt, and continued to be homeless. ECDSS offered mental health counseling, grief

counseling, domestic violence services and housing assistance. The mother did not engage in the services offered. Mental health counseling was discussed with the 16-year-old unrelated child and she declined. The CPS investigation was indicated and closed on 9/29/22.

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?** N/A

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

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:
ECDSS documented regular supervisor consultations throughout the investigation. 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: 07/28/2022 **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: 08:21 AM
Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? N/A

Child's activity at time of incident:

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

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	Aunt/Uncle	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Other Child - Unrelated	No Role	Female	16 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	47 Year(s)
Other Household 1	Father	No Role	Male	22 Year(s)

LDSS Response

Upon receipt of the SCR reports on 7/28/22, ECDSS initiated their investigation and coordinated efforts with law enforcement, sent notification to the Medical Examiner, District Attorney, and Child Advocacy Center and gathered information from first responders.

ECDSS interviewed the mother, who reported that at the time of the child's death, she was staying with the aunt for a short time, as she was homeless and living place to place. On 7/27/22 at 10:20PM, the mother and child were at the aunt's home. The mother had the child placed in his carseat to watch television. Approximately ten to fifteen minutes later, the mother gave the child a bath, placed him in a diaper, and gave him a bottle. The child fell asleep, and the mother placed him faceup on top of her bathrobe on the bed. The child was laid horizontally across the queen size bed, with his feet touching the mother. The mother laid with the child but did not fall asleep. The aunt came downstairs at 12:00AM and laid in the bed on the other side of the child. Around 2:30AM, the child began to fuss. The mother gave the child rice water and he drank two ounces and fell back to sleep. The mother reported she fell asleep and woke up at 7:50AM to use the bathroom. When she returned downstairs, the aunt was awake and laying in bed on her phone. The mother said the aunt told her the child did not look right. The mother grabbed the child and saw that his lips were blue. The mother began cardiopulmonary resuscitation and then the aunt took over. The aunt went to get her mother, who was a nurse, but she had already left for work. The aunt called 911 and first responders arrived to the home shortly after.

ECDSS interviewed the aunt, who reported that due to the mother being homeless, she allowed the mother and child to stay with her for a few days. On 7/27/22, the aunt returned home from work around 11:15PM, and got into bed with the mother and child. The aunt got up around 6:30AM, called her job to say she would be late, and went back to sleep. At 8:15AM, the aunt received a phone call from her job, so she got up and went upstairs to prepare to leave for work. The aunt went back downstairs to check on the child, as she believed it was odd that he was sleeping so late. The aunt touched him, and he was cold. The aunt alerted the mother, called 911 and the mother and aunt performed CPR until first

responders arrived. The unrelated 16-year-old child was interviewed and reported waking up on the morning of 7/28/22 to all of the noise and first responders being in her home. The 16-year-old reported no safety concerns and denied the need for counseling regarding the fatality.

The mother reported she received safe sleep information at the time of the child's birth and had a Pack N Play; however, the mother did not want to carry it from place to place. The mother reported she smoked a "blunt" while the child was watching television on the evening of 7/27/22.

ECDSS gathered information from law enforcement, the fire department and emergency medical services. First responders reported that upon their arrivals, the child had blood pooling and rigor mortis had set in, which indicated the child had been deceased for a few hours. The fire department reported on the bed with the child was a sheet, a blanket not on the child, two pillows not near the child and a bottle. Law enforcement attempted to speak with the father on the phone. The father had warrants for his arrest, and he refused to provide law enforcement with any information.

ECDSS obtained information from the child's pediatrician and the hospital. Hospital records showed that the subject child tested positive for marijuana at the time of his birth. The child was recommended for testing for possible concerns with his spinal cord. The mother followed up on recommendations for the child and he was up to date on well child exams and immunizations. The mother was counseled on safe sleep during appointments with the pediatrician.

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: ECDSS indicated the death would be referred to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062109 - Deceased Child, Male, 4 Mons	062110 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
062109 - Deceased Child, Male, 4 Mons	062110 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
062109 - Deceased Child, Male, 4 Mons	062111 - Aunt/Uncle, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
062109 - Deceased Child, Male, 4 Mons	062111 - Aunt/Uncle, Female, 22 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

Additional information:
ECDSS attempted to contact the father via telephone and letters. He was unable to be reached during the investigation.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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:
ECDSS completed a DV referral on behalf of the mother due to a history of intimate partner violence perpetrated by the father towards the mother. The mother was provided a 211 form that included services for mental health counseling, homelessness, domestic violence and shelter services.

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 16-year-old unrelated child was offered mental health counseling and declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ECDSS completed a DV referral on behalf of the mother. The mother was provided a 211 form that included services for mental health counseling, homelessness, domestic violence and shelter services. The mother did not engage in the services offered.

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
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☒ Used illicit drugs

☐ Was not noted in the case record to have any of the issues listed

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 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