Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-23-006

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

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This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased **Jurisdiction:** Erie **Date of Death:** 01/26/2023
Age: 3 month(s) **Gender:** Male **Initial Date OCFS Notified:** 01/26/2023

Presenting Information

An SCR report alleged that on 1/26/23 between 1:00 AM and 2:00 AM, the mother fed the 3-month-old female subject child and then brought her into the mother's bed to sleep. The mother woke up at 10:30 AM and found the child unresponsive. The mother called 911. When the police arrived at the home the child was cool to the touch and rigor mortis had set in. The police placed the child on the living room floor to perform cardiopulmonary resuscitation, which was unsuccessful. The child was pronounced deceased at an unknown time. It was believed the unsafe sleep situation contributed to the child’s death. The role of the father was unknown.

Executive Summary

On 1/26/23, Erie County Department of Social Services (ECDSS) received an SCR report regarding the death of the 3-month-old female child that occurred on the same day. The report alleged DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child. At the time of the death, the child was residing with the mother. The child's father lived in a separate home and visited with the child. The father had a 12-year-old child who resided in his home.

On the day of the death, the mother fed the child and changed her diaper between 1:00 and 2:00 AM. The mother placed the child to sleep on her back on the mother’s bed and then placed a pillow near her so she would not roll off. The mother laid horizontally across the foot of the bed and went to sleep. The mother woke up around 10:30 AM. The child was observed face down and was cold to the touch. The mother flipped the child over, called 911, and began rubbing the child to warm her body. The mother placed the child on the floor and initiated CPR at the instruction of 911 dispatch. First responders arrived and took over life-saving efforts. Rigor mortis had begun to set in upon the arrival of first responders. The child was transported to the hospital where she was pronounced deceased at 11:20 AM.

An autopsy was conducted and the medical examiner reported the preliminary cause of death was positional asphyxiation. The child's body had fixed lividity, with sparing around the nose and mouth area, which indicated the child was face down and was a classic sign of positional asphyxiation. There were no signs of trauma or abuse to the child, and the child appeared otherwise well cared for. Law enforcement investigated the death and reported it appeared to be an unsafe sleep situation. At the time the CPS investigation closed it was unclear what the status of the criminal investigation was.

ECDSS attempted contact with the 12-year-old sibling; however, the father refused to allow him to be interviewed. The father reported he had a child in another state, and ECDSS did not document that they asked the father about his involvement with that child, including any prior out-of-state child protective history. ECDSS documented in their conclusion narrative that they offered grief counseling services to the family; however, a conversation with the parents in which services were offered was not otherwise documented.

ECDSS found there was a fair preponderance of evidence to substantiate the allegations of the SCR report against the mother. ECDSS determined the mother placed the child in an unsafe sleep environment, which appeared to have contributed to the child's death, as indicated in the preliminary findings of the autopsy. The CPS investigation was indicated and closed on 3/28/23.

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

Explain:
The 12-year-old sibling lived in the father's home, did not visit the mother's residence, and had no contact with the mother or subject child; therefore, safety assessment tools were not completed in relation to the sibling. An appropriate determination was made given the information gathered during the investigation.

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:
Although all other casework activity was commensurate with case circumstances, ECDSS did not document an inquiry into the father's contact with his child who resided out of state. In addition, the casework contact with the parents did not reflect that services were offered in relation to the fatality.

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: 01/26/2023 **Time of Death:** 11:20 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:	Unknown

Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
Child's activity at time of incident:

- [x] 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	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Other Household 1	Father	No Role	Male	33 Year(s)

LDSS Response

Within the first 24 hours of the investigation, ECDSS contacted the source of the report, notified the medical examiner, law enforcement, the child advocacy center, and the district attorney's offices of the death. Throughout the investigation, ECDSS completed interviews with the parents, first responders, and medical staff.

ECDSS completed a visit to the mother's residence and interviewed the parents. There were no concerns for the condition of the home and the mother had formula, baby supplies, and appropriate sleeping arrangements, which included a bassinet for the child. The bassinet had a variety of miscellaneous items in it. The mother and father reported being educated on safe sleep guidelines when the child was born. The child typically slept in the bassinet, but more recently began sleeping on the mother's bed or sometimes the couch. The mother reported she was in receipt of prenatal care. The child was born at the hospital via an emergency C-section. The child was born prematurely and hospitalized for the three weeks following her birth. On the evening leading up to the child's death, the mother fed and changed the child between 1:00 and 2:00 AM and then placed the child to sleep on her back on the mother's bed. The mother put a pillow next to the child to prevent her from rolling off. The mother laid the child vertically down the bed and the mother laid at the child's feet horizontally across the bed. When the mother woke up around 10:30 AM, the child was face down and cold to the touch. The father reported he was not at the home when the death occurred.

The father visited with the child but reported the child had never been to his home. The father had a 12-year-old child who resided with him. ECDSS documented attempts to interview the 12-year-old, but the father reported he had nothing to do with the CPS investigation and would not allow it. The mother and father denied any substance misuse, and ECDSS documented no concerns for impairment during their contact with the parents.

ECDSS gathered information from collateral contacts including law enforcement and the pediatrician. The parents provided the same account of events to law enforcement as they did to CPS. The mother reported she did co-sleep with the child and law enforcement reported the death appeared to be an unsafe sleep situation. The child was in receipt of regular pediatric care following her discharge from the hospital and the mother brought the child to the necessary specialists. At the child's most recent appointment on 12/7/22, there were no concerns for the child's growth and development.

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? No
Comments: Though Erie County has an OCFS approved Child Fatality Review Team, ECDSS selected "Unknown or No Team" when asked if the case would be submitted for review on the 24-hour and 30-day fatality reports.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063764 - Deceased Child, Male, 3 Mons	063765 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
063764 - Deceased Child, Male, 3 Mons	063765 - Mother, Female, 33 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?	☒	☐	☐	☐

Additional information:
The father refused to allow the 12yo sibling to be interviewed.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
ECDSS documented in their conclucion narrative that grief counseling services were offered to the family. The casework

contacts with the parents did not reflect that services were offered to them; therefore, it was unclear if services were offered or accepted.

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:

- [x] 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
- [x] 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

The history greater than three years included SCR reports regarding the 12-year-old sibling. The sibling resided with his mother at the time of the SCR reports and the father was not a subject of the reports. In 2013, an SCR report alleged IG against a parent substitute and was unfounded. In 2016, an SCR report alleged XCP, IG, L/B/W, and S/D/S against the mother of the sibling. The sibling was removed and placed with a relative resource via an Article 1017 Direct Placement.

Known CPS History Outside of NYS

The father had a child who lived out of state. It was unknown if the father had CPS history out of state regarding that child.

Foster Care Placement History

In 2016, the sibling was removed from his mother and placed via a direct placement with the sibling's mother's previous foster parent. The father was visiting unsupervised with the sibling while he was placed. In April 2018, the sibling was sent home to his mother via a trial discharge. In May 2018, the sibling disclosed that his mother was hitting him with a

belt. The trial discharge ended and the sibling returned to the 1017 resource. On May 30, 2018, the sibling was discharged to the care of the father.

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 cited no required actions related to the fatality. ECDSS would like to note that, although the caseworker's progress notes do not document when grief counseling services were offered to the family, a supervisory note dated February 1, 2023 at the time of the 7-day safety assessment does reflect that grief counseling was offered. Additionally, documentation of a telephone contact with the father on February 23, 2023 reflects that "service needs" were offered, and a CPS Coordinator review of the case on March 28, 2023 also reflects that "services" were offered to both parents. We will be more cognizant in the future of being specific when documenting the nature of services offered and will remind our staff of same.

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