Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-23-011

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

Issue Date: Oct 11, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 04/25/2023
Initial Date OCFS Notified: 04/25/2023

Presenting Information

On the evening of 4/24/23, the 3-month-old subject child was ill. The father brought the child into his room and put the child in bed with him. The next morning, 4/25/23, the father woke up and the child was not breathing. The father called 911 and the child was transported to the hospital. Emergency medical services performed CPR enroute to the hospital. The child was pronounced dead at 8:33AM. The SCR report alleged the unsafe sleep environment contributed to the child's death. The mother was at work at the time of the incident.

Executive Summary

This report concerns the death of the 3-month-old subject child. Erie County Department of Social Services (ECDSS) received an SCR report regarding the child's death on 4/25/23. At the time of her death, the child resided with her 4-year-old sibling, and the two children were co-parented by the mother and father in their separate residences. On the day of her death, the subject child was at the father's house.

The morning of 4/25/23, the child woke around 5:00AM. The child felt hot, so the father unwrapped the blanket which had been used to swaddle the child, opened the bedroom window, and laid the child back down in her bassinet, which was located in the father's bedroom. About 10 to 15 minutes passed before the child began to cry. The father reported the child then felt cold, so he swaddled her and placed a blanket over her. Inside the bassinet was a boppy pillow, which was covered with an additional blanket. The child had been placed on the boppy pillow, on her side, with a pacifier. When the father awoke again around 7:00AM, the child's face was down, and the pacifier had come out of her mouth. When the father picked the child up, she felt limp. The father shook the child to wake her; patting her back and moving her around trying to get a reaction. The father placed the child on his bed and attempted CPR. He heard a gurgle sound and called 911. The fire department, law enforcement, and emergency medical services responded. The child was transported to the hospital where lifesaving measures continued with no success. The child was pronounced dead at 8:33AM.

The medical examiner was notified and performed an autopsy of the child. The cause of death was positional asphyxia and the manner was considered accidental. The record reflected an injury description of "unsafe sleep environment." The medical examiner reported no concerning marks, bruises or signs of trauma. Hospital records were consistent with the medical examiner's report and reflected no obvious signs of trauma. Law enforcement's investigation remained open at the time of writing.

ECDSS visited the mother and father's separate residences, interviewed both parents separately, and assessed the safety of the 4-year-old sibling. The sibling remained in the care of her parents, and they continued to share parenting time as agreed.

At the time this report was written, the CPS investigation remained open, therefore, no determination of the allegations had been made.

The father was offered and accepted a referral for bereavement services. The mother had previously been engaged in mental health services prior to ECDSS's involvement with the family. Although she remained enrolled in services, her engagement was sporadic and she had not been offered bereavement specific services.

PIP Requirement

ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? N/A

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:
On 4/25/23, the sibling made a disclosure of physical discipline which had not been further explored with either parent at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. The SS disclosed physical discipline and neither parent was questioned regarding this.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	ECDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/25/2023 **Time of Death:** 08:33 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: 07:10 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	Female	3 Month(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	25 Year(s)

LDSS Response

On 4/25/23, ECDSS received a report regarding the death of the subject child. ECDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ECDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. ECDSS conducted home visits to the parents' respective residences and assessed the safety of the sibling the same date the report was received.

ECDSS interviewed the parents regarding the events leading up to the child's death. A timeline was provided by the father. The father denied the child had been ill, as had been alleged. On the morning of the fatal event, the father woke up at 5:00AM upon hearing the child making noises. He checked on the child and she felt hot, like she had been sweating, so he unwrapped the blanket that had been used to swaddle the child and opened the bedroom window. The father placed the child back into her bassinet, which was located in the father's bedroom. About 10 to 15 minutes passed and the child began crying. The father described the child as feeling cold, freezing to the touch. In response, the father swaddled the child, wrapping her arms down by her side as she had recently begun to get herself out of the swaddle. The father placed a

sherpa blanket overtop of the boppy pillow, which was used inside the bassinet, placed the child on the covered boppy pillow, and placed a thick child-sized blanket overtop the child, tucked in around her. The child was placed on her side, which was the agreed-upon placement between the mother and father due to the child's flat head. The father said they alternate sides, and he had placed the child on her right side, with her pacifier. When the father woke again at 7:00AM, the child's head was facing down and the pacifier had come out of her mouth. The child's body had been positioned slightly angled upright and the child, while able to rotate her head, was not yet able to hold her head upright. The father picked the child up out of the bassinet, and she was limp. He attempted to rouse the child by tapping on her back and moving her around. He then placed her on his bed and attempted CPR; however, stated he did know how to perform CPR. He heard the child make a gurgling sound and called 911. The father was instructed on how to perform CPR by the dispatcher. The father denied anyone had previously discussed safe sleep recommendations with him and expressed he thought he was doing the right thing by keeping the child comfortable and warm. The child was transported to the hospital via ambulance where she was pronounced dead.

The mother was at work at the time of the incident and did not have further information regarding the fatal event. The mother confirmed the sleeping practice both parents used; the use of a boppy pillow covered with a blanket and placed inside the bassinet, as well as placing the child on her side. However, the mother no longer swaddled the child due to her moving around, and only placed the child to sleep on her side during the daytime. The sibling was interviewed and while aware of the subject child's passing, was unaware what happened. The sibling was at the father's house when the incident occurred but had been asleep in her bedroom.

ECDSS made relevant collateral contacts. The subject child was last seen by her pediatrician for a two-month well-child visit on 3/15/23 without concerns, and a 4/2/23 urgent care visit. The sibling was seen 2/17/23 for a 4-year well-child visit and 5/3/23 upon ECDSS's request with no concerns. On 8/1/23, ECDSS learned of an incident which occurred on 6/4/23 between the mother and father. The incident happened when the father was dropping the sibling off at the mother's home and resulted in the father breaking the mother's elbow. The mother called law enforcement and obtained an Order of Protection. Information gathering continued and the CPS investigation remained ongoing.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064686 - Deceased Child, Female, 3 Mons	064689 - Father, Male, 25 Year(s)	DOA / Fatality	Pending
064686 - Deceased Child, Female, 3 Mons	064689 - Father, Male, 25 Year(s)	Inadequate Guardianship	Pending

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 CPS investigation remained ongoing, therefore, the RAP had not yet been completed. On 8/1/23, ECDSS learned of a domestic incident that occurred between the mother and father. At the time this fatality report was written, only the mother had been interviewed regarding the incident. A service need regarding additional domestic violence service referrals had not yet been explored.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes

From: Unknown	**To:** Unknown

Explain:
As a result of a domestic incident that occurred on 6/4/23, in which the mother stated the father broke her elbow, the mother reported she obtained a stay away Order of Protection. The mother said the father had come to her home to drop off the sibling. The father got angry with the mother, made comments to the mother, and keyed her car. When the mother went towards the father's car, the father picked up and threw the mother to the ground. The mother stated things had been difficult since the passing of the subject child.

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? Yes

Explain:

The father was referred for bereavement services; however, it was unknown if he had engaged at the time this report was written. The mother had been involved in mental health services prior to the fatality, although her engagement was sporadic. The mother was not specifically referred for bereavement services. A service need following the domestic incident between the parents had not yet been explored at the time this report was written.

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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs

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

In 2019, ECDSS substantiated allegations of Inadequate Guardianship and Lack of Supervision against the father regarding the sibling. The parents had gotten into an argument in the presence of the sibling. The father removed the sibling from the family's car, while the sibling was still strapped into the car seat and placed the car seat on the sidewalk. The father then drove off with the car, while the mother was still in the car, leaving the sibling unattended for a short time. The mother was able to exit the vehicle and get back to the sibling.

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 (ECDSS) appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, accurately describe the unfortunate events and the actions taken in response. We must unfortunately concur with the fatality citation in that ECDSS failed to address the concern of physical discipline of the surviving sibling with either parent at the time the concern was disclosed. As a corrective action, the matter has been reviewed with the assigned caseworker and supervisor and it has been reinforced that all new concerns are to be explored and addressed with the applicable caregivers in a timely manner. Additionally, although not resulting in a citation, ECDSS acknowledges that an incident of domestic violence occurred between the parents during the course of the investigation and, at the time of the draft fatality report, not all interviews relative to this incident were completed. As the case remains open for ongoing investigation, a discussion has been held with the assigned caseworker and supervisor and they will ensure that all relevant interviews are completed and fully documented and that appropriate services are offered, including grief counseling for both parents and domestic violence services.

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