Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-24-001

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

Issue Date: May 28, 2024

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 **Jurisdiction:** Erie **Date of Death:** 01/06/2024
Age: 2 month(s) **Gender:** Male **Initial Date OCFS Notified:** 01/07/2024

Presenting Information

An initial SCR report was received on 1/4/24, alleging that at approximately 2:00AM, the father found the subject child unresponsive and not breathing. The father administered cardiopulmonary resuscitation (CPR). Additional interventions were required. The mother and father had no explanation as to what occurred. A subsequent report was received on 1/7/24, following the child's death, which alleged that the child had been stabilized at the hospital, intubated, and admitted to the Pediatric Intensive Care Unit (PICU). The child's toxicology report identified alcohol in his system. The child died due to cardiac arrest caused by alcohol on 1/6/24 at 9:57PM. The mother, father, and grandmother had no explanation as to how the child got alcohol in his system.

Executive Summary

This report concerns the death of the 2-month-old subject child. Erie County Department of Social Services (ECDSS) received an initial SCR report on 1/4/24 regarding the fatal incident and a subsequent SCR report following the child's death was received on 1/7/24. At the time of the child's death, he resided with his mother, father, maternal aunt, maternal grandmother, and twin sibling.

On the evening of 1/3/24, the mother and grandmother were home and caring for the children. The subject child was crying, so the grandmother provided a bottle to the child while the mother was with the twin sibling, who had been placed to sleep in the twin bassinet. The grandmother said the child had a 4oz bottle, then she laid him down on her queen-sized bed. The child fell asleep on the grandmother's bed. The child had been placed face-down, on his stomach to sleep, and the bed contained pillows and blankets, though the grandmother stated the blankets were off to the side of the bed, nowhere near the child, except for a thin blanket that was draped over the bottom of the child. The mother and grandmother reported checking on the child periodically with no concerns. The father arrived home from work around 11:00PM, and at that point the mother, father, and grandmother were all downstairs while the children were sleeping upstairs. When the grandmother next checked on the child around 2:00AM the morning of 1/4/24, she noticed something "was off" and picked up the child, who went limp. The grandmother ran downstairs and told the mother to call 911, which she did. The father woke up and initiated CPR. Emergency medical services arrived at the home and took over life-saving efforts and the child was transported to the hospital. The child arrived in cardiac arrest and with an anoxic brain injury, in extremely critical condition with multi-organ failure. The child was intubated and placed on a ventilator. Testing completed on 1/5/24 showed no evidence of brain activity, and the child died on 1/6/24 at 9:57PM.

The medical examiner was notified and performed an autopsy. The child was found with trace amounts of alcohol in his system, and a simple linear skull fracture to the parietal bone. The medical examiner stated neither the alcohol nor skull fracture caused the death. The final autopsy had not yet been received prior to the CPS investigation closing. The medical examiner noted the preliminary autopsy was undetermined; however, a later supervisory note stated the preliminary autopsy attributed the death to an unsafe sleep environment. Law enforcement investigated the death, and no charges were pending or anticipated.

Following the fatal incident, a safety plan was developed in which the sibling was to be cared for by relatives. As further information was learned regarding the positive toxicology and skull fracture, the safety plan changed, and Family Court was accessed. The sibling was ultimately placed pursuant to FCA 1017 with the maternal great grandmother. A corresponding Family Services Stage was opened.

The allegation of Inadequate Guardianship was substantiated against the parents, aunt, and grandmother, as they all resided together, shared caretaking roles to the subject child and sibling, and no one was able to explain the alcohol toxicology or skull fracture. DOA/Fatality was substantiated against the grandmother only. Poisoning/Noxious Substance was unsubstantiated as it was learned the amount of alcohol found could be a false positive and did not result in the child's death.

The family was provided with information on bereavement services; however, it was unknown if at the end of the CPS investigation any family member had engaged in such 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?** 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?** Yes

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:
The case remained open for ongoing services. The decision to indicate was appropriate; however, despite the sibling being removed from the parents care, there were no corresponding allegations added regarding the sibling.

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:	ECDSS determined the sibling was in immediate/impending danger as evidenced by Safety Assessments; however, no allegation regarding the sibling was added, whereas IG would have been appropriate as IG includes the imminent danger of harm.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	ECDSS will appropriately add and determine allegations regarding the nature, extent and cause of any condition enumerated in such report and any other condition that may constitute abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/06/2024 **Time of Death:** 09:57 PM

Date of fatal incident, if different than date of death: 01/04/2024
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: 02:03 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:

- [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	Aunt/Uncle	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Month(s)

LDSS Response

On 1/7/24, ECDSS received a report regarding the death of the subject child, which occurred on 1/6/24. ECDSS had previously received a report on 1/4/24 regarding the incident preceding the fatality and initiated their investigation upon receipt of that report. ECDSS coordinated their response with law enforcement, contacted the sources, completed a CPS history check, and informed the DA of the fatality. Safety of the surviving twin sibling was assessed, and a safety plan was implemented.

ECDSS interviewed all family members regarding the events leading up to the child's death and learned the aunt had been at work and was asleep at the time of the incident and therefore had not seen the children since 1/2/24. The father had been at work 2-10:00PM on 1/3/24 and did not return home until around 11:00PM, thus the grandmother and mother provided the timeline. The children had a twin bassinet that was primarily used; however, the evening of 1/3/24, the grandmother placed the subject child to sleep on her queen-sized mattress, while the mother placed the twin sibling to sleep in the bassinet in another bedroom. The subject child was placed face-down in the middle of the mattress and covered with a thin blanket on the bottom. The grandmother pushed other blankets and pillows away from the child. The child fell asleep, and the grandmother went downstairs. The mother and grandmother were unable to recall the specific length of time they were downstairs, but the mother stated at some point she did check on the subject child and he was asleep, breathing, and lying on his stomach. She returned downstairs, and at that point the father had returned from work and all three adults were downstairs. The father fell asleep on the couch and had not checked on the children between returning from work and falling asleep. The grandmother ended up returning upstairs at some point and sat on her bed. She looked at the child and noticed something was not right. She picked the child up, and he was limp. She ran downstairs and told the mother to call 911. The father woke up from the commotion and saw the child looked limp and was not breathing.

ECDSS learned from the hospital that the subject child's toxicology was positive for ethanol and no interventions provided by the hospital would have resulted in a positive test result. The surviving twin was tested and cleared. The treating physician stated they were unable to rule out a false positive and denied knowledge that the alcohol caused the cardiac arrest, as alleged. ECDSS spoke with the medical examiner who confirmed the alcohol would not have caused the child's death. Regarding the skull fracture found, there was no bleeding or bruising to the area and it was thought the fracture was relatively recent. The physician stated that type of fracture could happen due to a fall; however, all family members denied knowledge of any falls, drops, or bumps. The twin sibling was given a skeletal survey which did not show healing or new fractures. The children's pediatrician was contacted and denied concerns for the children's care since birth.

ECDSS developed a safety plan with the family, which was formalized by the 1017 placement of the sibling. The parents were permitted supervised contact with the sibling and a services case was opened for ongoing monitoring. At the close of the CPS investigation, the sibling was assessed safe with the relative resource. The most recent service plan reflected the parents would engage in substance use and mental health evaluations, as well as parenting classes.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
067029 - Deceased Child, Male, 2 Month(s)	067031 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
067029 - Deceased Child, Male, 2 Month(s)	067031 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
067029 - Deceased Child, Male, 2 Month(s)	067031 - Mother, Female, 20 Year(s)	Poisoning / Noxious Substances	Unsubstantiated
067029 - Deceased Child, Male, 2 Month(s)	067033 - Aunt/Uncle, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
067029 - Deceased Child, Male, 2 Month(s)	067034 - Grandparent, Female, 41 Year(s)	DOA / Fatality	Substantiated
067029 - Deceased Child, Male, 2 Month(s)	067034 - Grandparent, Female, 41 Year(s)	Inadequate Guardianship	Substantiated
067029 - Deceased Child, Male, 2 Month(s)	067034 - Grandparent, Female, 41 Year(s)	Poisoning / Noxious Substances	Unsubstantiated
067029 - Deceased Child, Male, 2 Month(s)	067032 - Father, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated
067029 - Deceased Child, Male, 2 Month(s)	067032 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
067029 - Deceased Child, Male, 2 Month(s)	067032 - Father, Male, 21 Year(s)	Poisoning / Noxious Substances	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	☒	☐	☐	☐

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?	☒	☐	☐	☐

If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The sibling was initially placed in a safety plan with the paternal grandparents, and the mother, father, aunt, and MGM agreed to abide by ECDSS's recommendation of being supervised at all times with the sibling. This plan was later formalized in Family Court following the filing of petitions and learning of the subject child's unexplained skull fracture. The sibling was directly placed (1017) by court with the maternal great grandmother effective 2/2/24.

Legal Activity Related to the Fatality

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

☒ Family Court ☐ Criminal Court ☐ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/02/2024	There was not a fact finding	There was not a disposition
Respondent:	067031 Mother Female 20 Year(s)	
Comments:	Petitions were filed in family court after it was learned the subject child had a skull fracture, to which none of the child's caretakers had an explanation for. A removal was requested and granted regarding the sibling. The sibling had been in a safety plan with paternal relatives, and was moved to the maternal great grandmother's care following court proceedings. The mother, father, aunt, and MGM were granted supervised contact only. A corresponding Family Services Stage was opened to monitor ongoing service needs. Court proceedings remained ongoing.	

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 sibling was placed pursuant to FCA 1017, not foster care, with the maternal great grandmother. Prior to his placement, paternal relatives were utilized as safety resources. An Early Intervention referral was made on behalf of the sibling, as required due to the indicated status of the case. Case management services through the Family Services Stage remained ongoing.

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? Yes
Explain:
The sibling was ultimately placed in the care of his maternal great grandmother as a result of evidence gathered during the CPS investigation. The sibling was 2-months-old at the time of the subject child's death and service needs specific to grief/bereavement were not identified.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was provided with bereavement resources. At the time the CPS investigation closed, it was unknow if grief-specific services were utilized. Due to ongoing service needs related to the siblings' placement, a services case remained open with the family.

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
- ☐ With fetal alcohol effects or syndrome

☐ Exhibiting withdrawal symptoms ☒ 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 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 must unfortunately concur that, although the safety assessment reflected immediate and impending danger to a child (i.e. the surviving sibling), no allegation regarding that child was added to the investigation. While acknowledging the citation, we would like to point out that the failure to add an allegation regarding the surviving sibling had no practical effect on the outcome of the case or on the safety of the surviving sibling. All alleged subjects from the investigation were indicated relative to the deceased child, and the surviving sibling was placed outside the home via a Family Court petition that listed the surviving sibling as a derivatively abused child. Since this was a citation strictly on the fatality investigation, the corrective action consisted of reviewing and discussing the matter with the assigned caseworker, her direct supervisor, and her administrative chain of command.

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