Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-20-027

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

Issue Date: Feb 25, 2021

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

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

☐ The death of a child for whom child protective services has an open case.

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 09/27/2020
Initial Date OCFS Notified: 09/27/2020

Presenting Information

An SCR report alleged on the morning of 9/27/2020, the mother fed the 4-month-old female subject child at approximately 6:00 AM. After feeding the child, the mother laid her down in bed, on a pillow, with the father who was sleeping. The mother left the home for an unknown period of time. Upon the mother's return to the home, the child presented with milk on her face and she was not breathing. The parents attempted CPR and they called EMS. The child was transported to the hospital where staff attempted to resuscitate her; however, they were not successful. The child passed away as a result of an unsafe sleeping environment. The 10-year-old and 1-year-old siblings had unknown roles. Subsequent SCR reports were received on the same day alleging the maternal uncle and his partner also had access to the child when she was found unresponsive and had allegations against them with regard to the child.

Executive Summary

This fatality report concerns the death of the 4-month-old female subject child that occurred on 9/27/2020. Three SCR reports were made on the same day alleging the mother placed the child in the bed with the sleeping father, which created an unsafe sleeping environment. The maternal uncle and his partner were listed as subjects on the report as they had access to the child prior to her being discovered unresponsive. At the time of her death, the child resided with her parents, and two siblings, ages 1 and 10 years. The children were assessed to be safe in the care of their parents.

Erie County Department of Social Services (ECDSS) coordinated investigative efforts with law enforcement immediately upon receipt of the SCR reports. An autopsy was performed; however, the results were not available at the time this report was written. The criminal investigation remained open pending the final autopsy results.

The parents reported the father was ill on the day prior to the child’s death and he slept throughout the day; however, was awake for most of the night. The child was acting normally prior to her death. On the morning of 9/27/2020, the mother handed the child to the father, who was laying bed. The father fed the child and placed her on her stomach inside of a U-shaped pillow with a pacifier. The father fell asleep and woke to the mother saying the child was not breathing. 911 was called and CPR was performed until first responders arrived, took over resuscitation efforts and transported the child to the hospital where she was pronounced deceased.

The investigation revealed on the night prior to the death, the uncle and his partner spent the night at the family's home. On the morning of the fatal incident, the uncle and his partner left the home; however, the mother's cousin and his partner were at the home that morning. The cousin's partner was present at the time the child was found unresponsive. The adults were interviewed and did not report any concerns for the parents’ care of the children.

ECDSS made collateral contacts including first responders, the pediatrician and family members. The collateral contacts did not have concerns for the safety of the surviving children.

ECDSS conducted home visits and the interviews with the family were thorough and documented timely. ECDSS completed Safety Assessments and required reports timely and accurately. After completing all casework requirements, ECDSS substantiated the father for DOA/Fatality and Inadequate Guardianship. The mother was substantiated for the Inadequate Guardianship of the child. The investigation revealed the parents had knowledge of safe sleep recommendations and placed the child at risk of harm by placing her in an unsafe environment. The record did not clearly reflect the basis for determination regarding DOA/Fatality against the mother with regard to the child. The maternal uncle

and partner were unsubstantiated for Inadequate Guardianship and DOA/Fatality. The maternal uncle and his partner did not reside in the home and did not have information relating to the death.

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

Explain:
Casework activity reflected that of best casework practice.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The decision to close the case was appropriate.

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: 09/27/2020 **Time of Death:** 08:54 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: 07:55 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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 20 Minutes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Male	29 Year(s)
Other Household 1	Other Adult - Maternal Uncle's Partner	Alleged Perpetrator	Female	21 Year(s)

LDSS Response

On 9/27/2020, ECDSS received three reports from the SCR concerning the death of the 4-month-old subject child. Within the first 24 hours of the investigation, ECDSS coordinated the investigation with law enforcement, contacted the sources of the reports, documented a CPS history check and notified the medical examiner and district attorney's offices of the death. Additionally, the safety of the surviving children was assessed.

A home visit was conducted, and the parents were interviewed. On the day prior to the child's death, the father slept for most of the day as he felt ill. The mother cared for the child as he slept. As a result of sleeping throughout the day, the father was awake during the night and did not sleep until around 5:00-6:00 AM on 9/27/2020. In the morning, the mother

handed the father the child and a bottle while he laid in bed. The mother left the home with the uncle and his partner who had spent the night. The father fed the child and placed her on the top corner of the bed, inside of a U-shaped pillow. The child fell asleep on her stomach with a pacifier in her mouth. Soon thereafter, the father fell asleep on the bed. The mother arrived home, woke the father and told him the child was not breathing. He called 911 while the mother performed CPR until first responders arrived. The father said the parents were aware of safe sleeping guidelines; however, he did not intend to fall asleep with the child. The father denied he rolled over on the child.

The mother reported the child spit up regularly, so they often placed the child on her side, thinking it would prevent her from choking. The mother said she handed the child to the father, who was laying in bed, and left the home with the other adults. When she came home, she checked on the child who was laying on her side with a burp cloth next to her head. She recognized something was not right and began to perform CPR while the father called 911. The mother reported the cousin's partner was also in the home when the child was discovered unresponsive, the cousin's partner took the siblings outside of the home.

The cousin's partner reported the cousin was not present at the time of the incident. She followed the mother into the bedroom when the child was found unresponsive and she did not have information to add.

The 10-year-old sibling did not express any concerns for the safety of the children. He said the child often slept in the same bed as the parents despite having her own bassinet. The sibling said the uncle’s partner woke him up and told him that something had happened, and that he was going to go sleep at her home. The sibling did not provide further information. The 1-year-old sibling was unable to be interviewed due to her age; however, appeared appropriately cared for.

First responders including law enforcement, EMS and the fire department did not have concerns for the condition of the home, or how the parents were reacting to the incident. The pediatrician reported the child was meeting growth and developmental milestones.

After all required casework was completed and the family was offered services in response to the fatality, the investigation was determined and closed timely.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055523 - Deceased Child, Female, 4 Mons	056304 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated

055523 - Deceased Child, Female, 4 Mons	056305 - Father, Male, 21 Year(s)	DOA / Fatality	Substantiated
055523 - Deceased Child, Female, 4 Mons	056305 - Father, Male, 21 Year(s)	Inadequate Guardianship	Substantiated
055523 - Deceased Child, Female, 4 Mons	056304 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
055523 - Deceased Child, Female, 4 Mons	056316 - Aunt/Uncle, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
055523 - Deceased Child, Female, 4 Mons	056316 - Aunt/Uncle, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
055523 - Deceased Child, Female, 4 Mons	056315 - Other Adult - Maternal Uncle's Partner, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
055523 - Deceased Child, Female, 4 Mons	056315 - Other Adult - Maternal Uncle's Partner, Female, 21 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:
The father of the 10-year-old sibling died prior to the investigation.

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 family was referred to grief counseling during the course of the investigation.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
The children did not need to be removed.

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 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 10-year-old sibling was referred to counseling in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered bereavement services and burial assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

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? 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
- ☐ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☒ Used illicit drugs

Infant was born:

- ☒ Drug exposed
- ☐ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/11/2020	Deceased Child, Female, 1 Days	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 1 Days	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the mother gave birth to the subject child on 5/10/2020. The mother's toxicology was positive for marijuana at the time of delivery. The child's toxicology report was pending.

Report Determination: Unfounded **Date of Determination:** 07/21/2020

Basis for Determination:
The investigation was initiated timely and the source of the report was contacted. A CPS history check was documented, and written notice of the report was provided timely. A Plan of Safe Care was implemented. Safe sleep guidance and information were provided to the parents. A home visit was made and interviews with the family and collateral contacts were thorough.

OCFS Review Results:
The allegations of Inadequate Guardianship and Parent Drug/Alcohol Misuse were unsubstantiated as the child's toxicology was unable to be tested. Medical professionals were contacted and there was not credible evidence the mother's marijuana use had a negative impact on the child. The mother stated that she did not use marijuana in the presence of the siblings.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/15/2018	Other Child - Uncle's Partner's Child, Male, 1 Years	Other Adult - Uncle's Partner, Female, 19 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	Yes

Report Summary:
The maternal uncle's partner gave birth to her child on 9/14/2018. The maternal uncle's partner was positive for marijuana at the time of delivery. Her child's toxicology was pending.

Report Determination: Unfounded | **Date of Determination:** 11/26/2018

Basis for Determination:
The allegation of Parent Drug/Alcohol Abuse was unsubstantiated. The maternal uncle's partner admitted to marijuana use while she was pregnant due to nausea, but there was no evidence of drugs in the home. The adults appeared sober during home visits.

OCFS Review Results:
The investigation was initiated timely, the family was interviewed, and the home was assessed. Safe sleep guidelines were discussed with the family. A CPS history check was completed. The 7-day Safety Assessment was completed timely. The record did not reflect a Plan of Safe Care was completed or monitored.

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

Issue:
Failure to complete, document, and monitor a Plan of Safe Care

Summary:
The record did not reflect a Plan of Safe Care was completed, documented or monitored.

Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06

Action:
ECDSS will complete, document & monitor a plan of safe care that specifically addresses the child affected by substance abuse and the affected caregiver. ECDSS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

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 New York.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Additional Local District Comments

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, 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, but we must unfortunately concur with the compliance issue noted by the reviewer with respect to a CPS investigation conducted by Erie County during the three years preceding the death of the child. With respect to the investigation of the SCR report dated September 15, 2018, we acknowledge that ECDSS failed to complete, document and monitor a Plan of Safe Care that would have been warranted by case circumstances. In response to similar concerns regarding the completion of Plans of Safe Care, ECDSS enacted a formal policy on December 18, 2018, instructing CPS staff to develop and document a Plan of Safe Care for any CPS-involved child who is affected by substance abuse or withdrawal as the result of prenatal drug exposure. Additionally, effective October 26, 2020, ECDSS began contracting with a local substance abuse treatment provider to assist with the development and monitoring of Plans of Safe Care.

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