Child Fatality Report

Report Identification Number: BU-19-005

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

Issue Date: Jun 10, 2019

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		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 01/20/2019
Initial Date OCFS Notified: 01/20/2019

Presenting Information

An SCR report alleged on 1/20/2019, an infant passed away unexpectedly. The child was one month old and his mother had a full-term pregnancy; he was otherwise healthy at the time of death. The child passed away while in the care of his mother and father.

Though the report did not describe the location of the infant when found, it was noted the father started giving the infant a bottle at 7:45 AM and fell asleep five minutes later in a recliner. When the father woke at 8 AM, he found the baby had turned blue. The father contacted police, who arrived at 8:10 AM. While awaiting EMS and police, the mother administered CPR. EMS intubated the child, but were unable to regain his circulation. The child arrived at the hospital at 8:30 AM and still had no circulation. He was pronounced deceased at 9:08 AM.

Executive Summary

This report concerns a five-week-old infant who passed away on 1/20/2019 while sleeping in an unsafe environment. Erie County Department of Social Services (ECDSS) investigated the fatality after an SCR report was made which alleged the parents were responsible for the unexpected death, as the child was otherwise healthy.

ECDSS collaborated with law enforcement during their investigation. It was learned the infant's father propped the child next to him in a recliner the morning of 1/20/2019, then fell asleep after briefly feeding him. The recliner was a part of a sectional couch upon which two adults and two other children were sleeping. The incident occurred at a relative's home. The father reported he had propped the child when the two of them became sleepy, and he dozed off for approximately ten to fifteen minutes.

The medical examiner conducted an autopsy, and the preliminary finding was probable positional asphyxia. The final autopsy report was pending at the time of this writing. It did not appear law enforcement made any arrests in connection to the fatality, as they confirmed having attended the autopsy where the preliminary results were learned.

The parents had arranged for the family to stay at their relative's home the night preceding the fatal incident, but did not set up a sleeping environment for the infant that could be determined safe according to current safe sleep standards. That night, the infant slept in a car seat on the floor next to the couch while the parents, 6-year-old sibling, and 9-year-old cousin slept on the couch. When the infant woke in the early morning for a feeding, the mother fed him then handed him to the father to continue feeding. The father fell asleep with the child and awoke to find him slouched over, pale, and with blue lips. He notified the mother and called 911. The mother performed CPR until help arrived. First responders took over resuscitative measures and transported the child to the hospital. Despite continued life-saving efforts, he was unable to be revived and was pronounced deceased.

As the father created an unsafe environment for the infant and fell asleep, he was held responsible for the incident and subsequent fatality; allegations against him were substantiated. The same allegations were unsubstantiated for the mother; she had no knowledge the father propped the child and then fell asleep, or that he was at risk of falling asleep while the vulnerable infant – developmentally unable to reposition himself – was in an unsafe environment.

As part of their response, ECDSS interviewed all family members and first responders present at the relative's home that day and assessed the safety of the sibling and other children in that home, ages 9 and 12. No safety concerns were

revealed for the surviving children, as the unsafe situation was isolated to the circumstances of the infant's vulnerability. A substance abuse evaluation was encouraged upon the parents' disclosure of consuming alcohol the evening prior (but reportedly not to the point of intoxication); however, this was declined. The family was referred to grief counseling, in which the parents and sibling became engaged. No further service needs were identified and the investigation closed after all casework activity was complete. ECDSS conducted a thorough investigation in accordance with multidisciplinary standards and recorded casework activity and required assessments timely and accurately.

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:
Safety assessments were timely and appropriate. The determination of allegations was appropriate given the supportive evidence gathered.

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. There was supervisory consultation documented, and all casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/20/2019 **Time of Death:** 09:08 AM

Time of fatal incident, if different than time of death: 07:50 AM

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 08:05 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? 15 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	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Other Household 1	Other Adult - Sibling's Father	No Role	Male	26 Year(s)

LDSS Response

ECDSS promptly initiated their investigation upon receipt of the SCR report concerning the fatality. Within 24 hours, ECDSS collaborated amongst their staff and law enforcement, notified the District Attorney and medical examiner, checked for CPS history, conducted home visits, and interviewed the family members.

The parents, sibling, and relatives with whom the family stayed overnight on 1/19/2019 were interviewed and provided consistent accounts of events leading up to the fatality. The children were put to bed at night, and the adults went to sleep between 1 and 2 AM. The infant was placed to sleep in a car seat on the floor next to the couch where the mother, father, sibling, and younger cousin slept. The other adults and child slept in a different part of the home. The parents reported the infant awoke in the morning for a feeding and the mother fed him, then handed him to the father around 7:30 AM to continue the feeding. The father said he started, but they both began to "doze off" so he put the baby next to him in the recliner portion of the sofa and propped the baby's head up; the record did not specify how. The father fell asleep and awoke 10-15 minutes later, finding the child "slumped over." He shook him in an effort to wake him, but noticed discoloration. He yelled and the mother awoke; 911 was called, and the mother administered CPR. Police responded and took over resuscitative efforts until EMS arrived and transported the child to the hospital, where he was later pronounced deceased.

The evening prior, the adults consumed alcohol. The father said he had two to three beers over the course of the evening and was not intoxicated. The mother said she had four glasses of wine and was "slightly buzzed." All adults denied impairment, and there was no evidence the father was intoxicated at the time of the incident. Upon investigation, no concerns were revealed for a history of drug or alcohol abuse by either parent. ECDSS made a referral for and requested the parents undergo mental health and substance abuse evaluations, though they denied the necessity and refused.

The infant's regular place of sleep at the family's own home was in a Rock 'n Play next to the parents' bed, though ECDSS observed they had a crib. The parents reported they never intentionally co-slept, but both had experienced times when they momentarily fell asleep and jolted awake while holding the baby. The parents confirmed they were advised of infant sleep safety prior to the fatality. ECDSS discussed safe sleep with the family in detail and provided an array of written materials regarding child safety and prevention.

ECDSS encouraged medical examinations of all children who were in the home at the time of the fatality. The children were promptly examined and there were no medical concerns for them, nor did the pediatricians have any concerns for abuse or neglect. The pediatrician also had no concerns for the infant, having been last seen for a routine exam on 1/8/19 as healthy with no abnormal findings. All children were interviewed, and the two children sleeping on the couch confirmed the infant had not been on the same surface as them when they initially went to sleep. The only inconsistency was from the sibling's account, where he reported he was the first of those sleeping on the couch to wake. He said he saw the infant on the footrest of the recliner and woke his father; the father reported he had awoken first.

The family denied that either the infant or anyone else in the home was recently ill. The infant had been given an ingestible homeopathic remedy for gas the evening prior, but had otherwise taken no medication.

ECDSS' case determination was supported by information from the medical examiner and interviews with the family and collateral contacts. ECDSS used multiple resources at their disposal to attempt contact with the sibling's father, to no avail. Once all casework activity was complete, ECDSS ended their involvement.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical 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 reviewed by an OCFS approved Child Fatality Review Team?No

Comments: At the time of the fatality, Erie County Department of Social Services did not have an OFCS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
049697 - Deceased Child, Male, 1 Month(s)	049699 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
049697 - Deceased Child, Male, 1 Month(s)	049698 - Father, Male, 31 Year(s)	DOA / Fatality	Substantiated
049697 - Deceased Child, Male, 1 Month(s)	049699 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
049697 - Deceased Child, Male, 1 Month(s)	049698 - Father, Male, 31 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:
Despite multiple efforts to locate the biological father of the surviving sibling for an interview, contact was unable to be made.

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:
Grief services were offered, and the parents and sibling partook. Other services were offered but refused. The parents were asked if they felt any other services would be beneficial, and the parents declined the need.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☒	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
It was noted funeral arrangement services were to be offered in addition to the other numerous services that were offered, but it was unclear if that was done.

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 family was referred to and participated in grief counseling, including the surviving sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was referred to and participated in grief counseling. Grief services were offered to other family members. The parents were referred for mental health and substance abuse evaluations, but refused.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	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

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 is no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

We at the Erie County Department of Social Services appreciate the opportunity given us to review the draft report in

advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No