Child Fatality Report

Report Identification Number: BU-22-006

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

Issue Date: Sep 23, 2022

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: 27 day(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 04/20/2022
Initial Date OCFS Notified: 04/20/2022

Presenting Information

Niagara County Department of Social Services (NCDSS) received an SCR report alleging on 4/20/22 at an unknown time, the mother was breastfeeding the subject child in the back bedroom of the home. The mother rolled onto the child for an unknown period of time. The father found the mother and subject child in the bedroom, and the subject child was unresponsive. The unrelated home member was present, and contacted 911. Police and ambulance services arrived to the home and transported the subject child to the hospital. The subject child had blood on his nose and blood was found on the floor of the bedroom. The subject child was brought into the hospital at 12:12PM and pronounced deceased at 12:43PM, as a result of cardiac and respiratory distress.

Executive Summary

This fatality report concerns the death of a 27-day-old male subject child that occurred on 4/20/22. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, and Internal Injuries against the mother, father, and 46-year-old unrelated home member. At the time of his death, the subject child resided with his mother, father, and four surviving siblings, ages 1, 3, 5, and 11. The unrelated home member was staying with the family temporarily to assist with caring for the children but left the family's residence and returned to her home after the subject child's death. The father had two other children who resided out of state; however, he refused to provide contact information for their mother and attempts to locate those children were unsuccessful.

Niagara County Department of Social Services (NCDSS) completed collateral and casework contacts and learned that on the morning of 4/20/22, the mother was breastfeeding the subject child while in the parents' bed with the father. The father went to the bathroom to take a shower and returned to the parents' bedroom approximately 10 to 15 minutes later. The father observed the mother asleep in the bed with the subject child latched to her breast and blood coming from his mouth. The unrelated home member heard the parents screaming and called 911 while the father began cardiopulmonary resuscitation. The father continued life-saving measures until emergency medical services arrived at the residence and took over. The subject child was transported to the hospital and pronounced deceased at 12:43PM.

An autopsy was performed, and the final cause and manner of death had not yet been received at the time this report was written. Hospital staff that attended to the subject child reported no concern for traumatic injury but noted that there was a strong possibility of suffocation. There have been no criminal charges filed pertaining to the subject child's death.

The family was offered bereavement services following the subject child's death. The allegations of the report were unsubstantiated against the mother, father, and unrelated home member, as NCDSS did not find there was a fair preponderance of evidence to support that the parents failed to meet minimal standards of care for the subject child.

PIP Requirement
This review resulted in a citation related to casework practice. In response, NCDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the NCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, NCDSS will review the plan(s) and revise as needed.

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? 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:
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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	Although NCDSS did assess the safety of the surviving siblings, the Safety Assessment Tool was not completed within 24-hours of the subject child's death being reported.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	NCDSS must document and approve a safety assessment within 24-hours of receipt of the fatality report. The 24-hour assessment does not replace, but is in addition to, the seven-day safety assessment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/20/2022 **Time of Death:** 12:43 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? Yes
Time of Call: 11:50 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
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	27 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	46 Year(s)

LDSS Response

Upon receipt of the SCR report, NCDSS coordinated their investigation with law enforcement, notified the district attorney's office, spoke with collateral sources, interviewed the parents, and offered services regarding the fatality.

NCDSS interviewed the mother, father, and unrelated home member. The father reported that the subject child had been having difficulty sleeping in the days preceding his death, but the father denied the subject child was ill. The father stated that around 11:19AM on 4/20/22, he took a photo of the mother and subject child sleeping. The mother awoke shortly after and began breastfeeding the subject child in the parents' bed. The father was in bed with the mother and subject child when he decided to take a shower. The father was in the bathroom for 10 to 15 minutes before returning to the bedroom

and observing the mother asleep in bed, with the subject child still latched to her breast. The father woke the mother and took the subject child from her. The father reported the subject child had blood coming from his mouth and appeared pale. The unrelated home member heard the mother yell “the baby” and called 911. The unrelated home member translated CPR instructions to the father and dispatch advised the father to put the subject child on the floor while continuing life-saving measures until EMS arrived. EMS responded and the subject child was transported to the hospital via ambulance, where he was later pronounced deceased.

The mother corroborated the father’s version of events, and both the mother and unrelated home member denied that the mother had rolled over on the subject child. The unrelated home member described the subject child as being limp and pale, with blood “oozing” from his nose and mouth. The 11-year-old was interviewed and reported hearing the mother scream, seeing blood on the subject child’s face, and the father performing CPR, but did not disclose any further concerns to NCDSS. Interviews with the 3 and 5-year-old siblings were attempted; however, unsuccessful due to their age and development. During a home visit, NCDSS observed a portable crib that the subject child reportedly slept in and discussed safe sleep guidelines with the parents, though the record did not reflect if the parents were aware of safe sleep guidelines prior to the subject child's death.

NCDSS learned that the mother was induced with the subject child and gave birth at 37 weeks gestation. The subject child was a twin; however, the twin passed away in utero from unknown complications. Numerous collateral sources were contacted and expressed no concerns for the parents’ ability to care for the subject child or surviving siblings. The four siblings’ safety was assessed, and they were deemed safe with the mother and father.

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
Comments: NCDSS adhered to previously approved protocols for joint investigations by notifying the District Attorney's office of the death and coordinating efforts with Law Enforcement.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Niagara County Department of Social Services referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061111 - Deceased Child, Male, 27 Days	061112 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
061111 - Deceased Child, Male, 27 Days	061112 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
061111 - Deceased Child, Male, 27 Days	061112 - Mother, Female, 29 Year(s)	Internal Injuries	Unsubstantiated
061111 - Deceased Child, Male, 27 Days	061113 - Father, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated

061111 - Deceased Child, Male, 27 Days	061113 - Father, Male, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
061111 - Deceased Child, Male, 27 Days	061113 - Father, Male, 34 Year(s)	Internal Injuries	Unsubstantiated
061111 - Deceased Child, Male, 27 Days	061114 - Unrelated Home Member, Female, 46 Year(s)	DOA / Fatality	Unsubstantiated
061111 - Deceased Child, Male, 27 Days	061114 - Unrelated Home Member, Female, 46 Year(s)	Inadequate Guardianship	Unsubstantiated
061111 - Deceased Child, Male, 27 Days	061114 - Unrelated Home Member, Female, 46 Year(s)	Internal Injuries	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:

NCDSS attempted to locate the father's other two children to assess their safety face-to-face; however, attempts were unsuccessful and the father would not provide contact information for their mothers.

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 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	☐	☐	☐	☐	☐	☒	☐

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:
Bereavement services were offered on behalf of the surviving siblings. The family briefly worked with a behavioral health specialist, who provided the family with resources for long-term counseling services, as the mother expressed the family was struggling to cope with the subject child's death. The mother felt the 11yo sibling was "bottling up" her feelings, and the 3yo sibling was noted to be crying more frequently and stating he missed the subject child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the mother and father following the subject child's death. The family briefly worked with a behavioral health specialist, who provided resources for long-term counseling services. The mother expressed that she and the family were struggling to cope with the subject child's death.

History Prior to the Fatality

Child Information

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/08/2021	Sibling, Female, 11 Years	Mother, Female, 29 Years	Educational Neglect	Unsubstantiated	Yes

Report Summary:
The SCR report alleged that the 11-year-old sibling missed 33 days of school and as a result, was failing. The mother was aware but failed to adequately address the situation.

Report Determination: Unfounded **Date of Determination:** 01/26/2022

Basis for Determination:
NCDSS determined there was no credible evidence to substantiate the allegation. The SM reported the family had COVID and the school was aware; however, the children would not be back to school due to increased COVID risk. The SM explained she had an autoimmune disorder which resulted in her being hospitalized from COVID and did not want to put the family at risk, and she was pregnant. A Spanish liaison with the school brought schoolwork for the children. The SM completed medical exemption paperwork and looked into homeschooling. NCDSS discussed with the school their legal obligation to assist the SM with an education plan and the school reported the children would pass for the year.

OCFS Review Results:
NCDSS initiated their investigation, contacted the source of the report, assessed for safety, and interviewed all household members when age appropriate; however, the record reflected the 11-year-old was only interviewed about questions pertaining to the Risk Assessment Profile and not specific to the allegations of the report. The CPS history check was completed late on 12/14/22.

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

Issue:
Review of CPS History
Summary:
The history check was completed late on 12/14/22.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:

Within 1 business day of a report, NCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, NCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

The record does not reflect there were full interviews with the children. The record reflected the 11-year-old sibling was only interviewed about questions pertaining to the Risk Assessment Profile, and not interviewed regarding her school absences which were specific to the allegations of the report.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

NCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

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 is no known 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.

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