Child Fatality Report

Report Identification Number: NY-22-029

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

Issue Date: Sep 26, 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: 3 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 04/25/2022
Initial Date OCFS Notified: 04/25/2022

Presenting Information

A report was received from the SCR alleging that on 4/24/22, at approximately 8-9 PM, the father was in the living room feeding the subject child. The subject child made a sudden movement and fell out of the father's arms and hit the right side of his head on the ground. The subject child sustained bruising to his eyes, nose, and mouth. The mother was in the next room and was aware of what happened. The mother and father failed to seek medical attention for the child. On 4/25/22, at approximately 4AM, the father woke up to feed the child and then placed him back to sleep. At an unknown time, the father woke and found the child cold and unresponsive. The father transported the child to the emergency room. The child arrived at the hospital with no pulse and was pronounced dead at 10:40AM.

Executive Summary

This report concerns the death of the 3-month-old male subject child who died on 4/25/22. At the time of the child's death, he resided with his mother, father, and 3-year-old sibling. The family was known to the Administration for Children Services (ACS).

The investigation revealed the mother and father had a verbal dispute on 4/22/22, regarding the father's concern for the mother's infidelity. The dispute carried on through 4/23/22 when the father went through the mother's phone. On 4/24/22, the father was caring for the subject child while the mother was in another room. The mother heard a thump, and the subject child began to cry. The mother went to check on the child and the father reported the child fell out of his arms while feeding but the child was fine. The mother went back to the other room and heard another loud thud and crying from the subject child. Again, the father reported the child was fine. The mother observed the child to have swelling around his eyes and the father placed an ice compression on the subject child's face. On the morning of 4/25/22, the father woke the mother and was upset, crying, and reported the subject child was unresponsive. The mother instructed the father to bring the subject child to the hospital. The father brought the child to the hospital where he was pronounced dead at 10:40AM.

An immediate safety plan for the sibling was deemed necessary for several reasons. The mother reported the father had a history of violence, and despite this, she failed to seek immediate medical attention after hearing the child fall the first time. There were inconsistencies with the parents' account of the fatality, and ongoing discord between the mother and father. Due to the mother's inability to care for the sibling, he was placed in foster care.

ACS coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final autopsy report was not yet received at the time this report was written. The medical examiner attributed the child's death to abusive head trauma and listed the manner of death as homicide on the death certificate. The preliminary findings revealed bruising under both eyelids, a torn frenulum, abrasions to the nostrils and ears, and abrasions to the child's face. The ME reported the injuries were consistent with a finger being shoved under the child's eyes while holding the child's face to try and close his mouth. The autopsy further revealed a complex set of skull fractures from the parietal to the occipital bone, bilateral hemorrhaging of the optic nerve root, and bilateral subdermal hematomas. The ME stated the injuries were not consistent with a fall, as the father claimed. The father was arrested and charged with Murder in the 2nd Degree, one count of Manslaughter in the 1st Degree, one count of Reckless Assault of a Child, and one count of Assault in the 2nd Degree. At the time of this writing, the father remained incarcerated pending trial. Further collaboration with law enforcement revealed in 2006, the father was arrested and charged with homicide for the death of a child he shared in common with another female.

ACS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, the medical examiner, and relatives. ACS provided fatality-related services to the mother upon receipt of the fatality report. ACS filed an Article 10 severe abuse petition against the mother and father, and the sibling remained in foster care.

PIP Requirement
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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?** No

Explain:
ACS was appropriate in determining the allegations regarding the subject child; however, failed to add and substantiate allegations regarding the sibling. ACS filed a severe abuse petition against the parents for the sibling and removed and placed the child in foster care.

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

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. The case remained open for foster care services following the determination of the investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS substantiated allegations regarding the subject child, filed a severe abuse petition against the parents for the sibling, and removed the sibling; however, they failed to add and substantiate allegations against the parents for the sibling.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult NYCRO if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/25/2022 **Time of Death:** 10:40 AM

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

County where fatality incident occurred: New York
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
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? Unknown if they were impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **UNKNOWN**

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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Other Household 1	Sibling	No Role	Male	3 Year(s)

LDSS Response

On 4/25/22, ACS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, ACS initiated their investigation within 24 hours and coordinated efforts with their MDT. ACS reviewed the family's history, which revealed significant CPS and law enforcement involvement in New York and a neighboring state. Through ACS' law enforcement review, they discovered the father had been charged with homicide in 2006; however, he was not indicted.

ACS interviewed the mother and she reported ongoing discord with the father in the days leading up to the child's death. The father accused her of infidelity and his behaviors became erratic as he became more detached from the mother and subject child on 4/22/22 and 4/23/22. On 4/24/22, the father requested the mother allow him to care for the subject child. The mother reported while the father was feeding the child in another room, she heard several loud thumps and then the subject child cried. The mother checked on the child each time and the father reported the child was fine. The father told the mother the child fell out of his arms while he was feeding him. At some point in the evening on 4/24/22, the mother observed the subject child with bruising under both eyes. The father held an ice pack on the child's face and the mother provided an infant-sized dose of pain reliever to the subject child. The mother woke the next morning to the father abruptly pulling her out of bed. The father was erratic and requested the mother's "forgiveness." The mother viewed the subject child wrapped in a blanket in the living room with clear facial bruising. The father would not allow the mother to enter the room to observe the child closer. The mother told the father to bring the child to the hospital and "tell them it was an accident." The mother reported receiving a phone call from the hospital around 10:00AM, requesting she come to the hospital. The child was pronounced dead at 10:40AM. ACS was unable to interview the father due to his arrest and pending criminal trial.

The sibling was assessed, and it was determined a safety plan was necessary. The mother did not have an alternate plan for the sibling; thus, ACS conducted an emergency removal of the sibling, and the child was placed in a certified foster boarding home. The record reflected a CAC interview was conducted with the sibling, though the record did not reflect specifics of the interview. A petition was filed in court following the emergency removal and a corresponding Article 10 severe neglect petition was filed against the mother and father. At the time of this writing, the sibling remained in foster care. A half-sibling resided out of state with her father. That child was assessed by child welfare in the state she resided and was safe in the care of her father. The half-sibling had no contact with the mother.

ACS determined there was a fair preponderance of evidence to indicate the allegations of DOA/Fatality, Lacerations/Bruises/Welts, Lack of Medical Care, and Inadequate Guardianship against the mother and father regarding the subject child. ACS found the parents to be inconsistent in their recollection of the incident leading to death. The ME ruled the death a homicide and it was noted that both parents failed to obtain immediate medical attention for the child following his injuries.

ACS failed to consider adding and substantiating allegations against the parents for the sibling, despite filing a severe abuse petition and placing the sibling in foster care. Appropriate fatality-related services were offered to the mother and ongoing court-ordered services were mandated.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: ACS coordinated efforts with law enforcement and notified the DA's office of the death.

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061261 - Deceased Child, Male, 3 Mons	061262 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
061261 - Deceased Child, Male, 3 Mons	061262 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
061261 - Deceased Child, Male, 3 Mons	061262 - Mother, Female, 33 Year(s)	Lacerations / Bruises / Welts	Substantiated
061261 - Deceased Child, Male, 3 Mons	061262 - Mother, Female, 33 Year(s)	Lack of Medical Care	Substantiated
061261 - Deceased Child, Male, 3 Mons	061263 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
061261 - Deceased Child, Male, 3 Mons	061263 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
061261 - Deceased Child, Male, 3 Mons	061263 - Father, Male, 34 Year(s)	Lacerations / Bruises / Welts	Substantiated
061261 - Deceased Child, Male, 3 Mons	061263 - Father, Male, 34 Year(s)	Lack of Medical Care	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:
Relevant collateral sources were interviewed. ACS interviewed the mother and observed the sibling. Due to the ongoing criminal investigation, the father was unable to be interviewed.

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:
ACS gathered sufficient evidence to assess for risk of the sibling and removed and placed the child in foster care. ACS filed a severe abuse petition due to the circumstances surrounding the death. The mother was mandated by the court to engage in services and was compliant with the conditions of her orders at the time of this writing.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: The sibling was removed and placed in foster care due to the conditions surrounding the death.				

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:**
04/29/2022	There was not a fact finding	There was not a disposition
Respondent:	061263 Father Male 34 Year(s)	
Comments:	A neglect petition was filed in family court against the mother and father regarding the surviving sibling.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
04/29/2022	There was not a fact finding	There was not a disposition
Respondent:	061262 Mother Female 33 Year(s)	
Comments:	A neglect petition was filed in family court against the mother and father regarding the surviving sibling.	

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
04/26/2022	Father	Pending	NA
Comments:	On 4/25/22, the father was arrested and on 4/27/22 he was charged with murder in the 2nd degree, manslaughter in the 1st degree, assault in the 2nd degree, and reckless assault of a child in the 2nd degree.		

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:
ACS provided fatality-related services to the family. The sibling was removed and placed in non-kinship foster care. Services for reunification were provided and, at the time of this writing, the mother was engaged with mandated services.

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:
ACS provided foster care services to the sibling following the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Appropriate fatality-related services were offered to the mother. The mother was engaged in bereavement, mental health, and domestic violence services.

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?	Yes
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

In 2014, the mother and father of the half-sibling were involved in a domestic incident. The mother punched the father of the sibling while he was holding the child. The mother was arrested for the assault and the investigation was indicated. The family did not reside in the jurisdiction of New York and the half-sibling was removed from the mother and placed in foster care by CPS in a neighboring state.

An Out of Town Inquiry (OTI) was opened in 2014 in order to complete a home study for the half-sibling out of state with that child's father. The home was approved and it was determined the father of the half-sibling was appropriate and there were no child protective concerns identified. Family Court in the neighboring state granted custody of the half-sibling to her father. Sometime after 2014, the half-sibling and her father moved out of their home state and the record revealed no further child welfare intervention.

Known CPS History Outside of NYS

ACS contacted CPS in a neighboring state and learned of child welfare intervention, though the record did not reflect the timeframe of CPS involvement. The record revealed a petition for physical abuse was filed in Family Court in that state against the mother and father regarding the half-sibling due to the sibling having marks and bruises about her body. The record did not reflect whether the 2006 homicide was a CPS investigation.

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