Child Fatality Report

Report Identification Number: SV-18-022

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

Issue Date: Aug 07, 2018

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: 2 year(s)

Jurisdiction: Westchester
Gender: Male

Date of Death: 04/16/2018
Initial Date OCFS Notified: 04/17/2018

Presenting Information

SCR reports were made on 4/17/18 and 4/19/18 regarding the 2yo SC. It was alleged on 4/16/18, SC was in the care of SF. When SM came home, she found SC face down on the bed, unresponsive, with multiple injuries to his body. Neither parent had an explanation for SC's condition or contacted EMS, though they transported him to the hospital. SC was pronounced dead, allegedly as a result of cardiac arrest brought on by SF assaulting him. The injuries allegedly included extensive bruising on SC's forehead, arms, legs, ears, and trunk, what appeared to be a bite mark on his arm, a long, deep gash on his lip, and a large area that was red and swollen behind his ear. It was alleged SF physically harmed SC several times in the past and SM was aware but continued to leave SC in his care. While she was at work, SF allegedly provided her with an explanation for the cut on SC's lip, stating he had fallen and only required a bandage. The report further alleged when SF drove them to the hospital, he warned SM to say SC had been staying with a friend, not him.

Executive Summary

On 4/17/18, Westchester County Department of Social Services (WCDSS) received an SCR report regarding the death of the 2yo male SC. The SC had multiple injuries at the time of his death, and as neither parent could explain the injuries, both were alleged subjects of the apparent abuse.

The SC was brought to the hospital on the date of the report, unconscious and with multiple visible injuries, which included bruising on his face, head, arms, legs, and trunk, and a laceration on his lip. The death certificate revealed the immediate cause of death was, "Blunt force injuries with lacerations of liver, pancreas, duodenum; internal hemorrhages." The manner of death was homicide. The ME's autopsy report was still pending at the time this report was written.

WCDSS coordinated the investigation with LE, though LE conducted separate interviews. On 4/17/18, SF was arrested in connection with the fatality. WCDSS interviewed SF in jail. The SF was the last to see the SC alive, as he cared for SC on 4/16/18 while SM worked, approximately between 7am and 6pm. SF denied inflicting harm to the SC at any time, nor did he admit to knowledge of anyone else harming the SC. He stated SC tripped in the doorway that day, and bumped his head and cut his lip, and required minimal treatment which he administered. When SM was interviewed, she too made no admissions of inflicting harm or knowing of anyone harming SC. She found SC cold and unresponsive in his bed, with multiple injuries, when she returned from work. In response, she attempted CPR with no result, then called SF who had stepped out to run errands. He provided no information about the SC's condition, and transported SM and SC to the hospital. SM reported the SC had no injuries, marks or bruises when she left him with SF the morning of his death.

The source of the subsequent report who physically observed the SC, as well as the CW who viewed LE's photographs of the child, noted it appeared some of the SC's marks/bruises appeared to be in multiple stages of healing; however, WCDSS did not make further inquiries on this topic to other medical providers.

SM reported SF was physically abusive to her on a regular basis in front of SC, though police were never called and SM reported there were never any injuries. WCDSS arranged for Victim's Advocacy Services for SM. SF denied DV. Neither parent had CPS history or any other children together. SF had one other child with another woman; he was 9 years old. WCDSS made diligent efforts to locate and interview him. WCDSS contacted the SS's mother, and though she was made aware of the concerns, she refused to allow WCDSS to see or speak with the SS. Beyond a phone interview, the SS's BM would not cooperate with the investigation.

WCDSS addressed additional concerns which arose during interviews. A familial contact noted having observed SM inflict excessive physical discipline on SC in the past, in response to SC biting her. SF said SM drank to excess and had seen her give SC alcohol to drink. SM admitted having given SC a sip of alcohol on at least one occasion. SF acknowledged this occurrence, adding he had allowed SM to drive while intoxicated with SC in the car. This information was taken into consideration when determining allegations: such actions and inactions were the basis of substantiating the allegation of IG against SM and SF, and PD/AM against SM.

With respect to the alleged abuse, WCDSS documented having found some credible evidence to substantiate the allegations of DOA/Fatality and L/B/W against both parents. SF was facing criminal charges related to the death of the SC. Both parents acknowledged SC was without injury prior to being left in the sole care of SF for approximately 11 hours, after which time SC was discovered to be in grave condition. SM said she believed SF possessed and sold drugs in the home, and was violent towards her on multiple occasions, yet she continued to leave SC in SF's care. Despite her knowledge of SF's propensity towards violence, SM did not take protective measures regarding the SC. Ultimately, SF was found responsible for the serious injuries which led to the SC's death. SF remained incarcerated at the time this report was written.

WCDSS completed a thorough investigation which included detailed interviews, a multitude of collateral contact information, the offering of services, and efforts to assess a SS. WCDSS completed all safety assessments and reports in a timely manner and closed the case. On 7/17/18, another SCR report was made regarding the fatality, with no new information. WCDSS initiated that investigation promptly.

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:
All safety assessments were timely and appropriate.

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 case record had detailed notes regarding supervisory and administrative consultation. The decision to close the case was appropriate after a thorough investigation had been completed.

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: 04/16/2018 **Time of Death:** 07:01 PM

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

County where fatality incident occurred: Westchester
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not impaired.

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	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)

LDSS Response

Upon receipt of the SCR reports, WCDSS spoke with sources, LE, DA, Victim Advocacy Services, and a neighbor, and attempted a home visit. WCDSS learned LE interviewed SF separately, and that he was incarcerated shortly thereafter. WCDSS received medical records and learned information about SC's injuries.

WCDSS interviewed SF in jail, and later interviewed SM. According to both parties, SC stayed home from DC on 4/16/18 as he appeared congested. The parents reported SF cared for SC at their home while SM was at work. SF stated when he and SC returned home in the morning from dropping off SM, SC tripped, hitting his forehead and cutting his lip. SF stated he applied ice to SC's forehead and put ointment and a bandage on his lip. He denied SC sustained any other injuries. He said the rest of the day, they watched television and napped. SC was still sleeping when SM returned home, at which point SF left to run errands. He received a phone call from SM shortly after leaving, and she was crying and asking what happened to SC. He said he had no idea and returned home, seeing SC was unresponsive. He then drove them to the hospital. SF continually denied doing anything to harm SC, and further denied usage of corporal punishment beyond the occasional "pop" to his hand or buttocks.

SM reported to WCDSS that before work on 4/16/18, she gave SC a "natural" medication as well as an antihistamine for cold symptoms, and gave dosages as noted on the boxes. WCDSS did not see the medications and it was not noted whether the ME was informed, though it was apparent from the record that this was unrelated to the death. SC had no other medical conditions. SM said she texted SF around 9am to see how SC was doing, and SF informed her SC fell and cut his lip while coming into their building, but minimized it. She checked in with SF at other times that day. SM got home around 5:50pm and checked on SC, who she found lying face down in bed with a blanket on him, noticing nothing unusual from where she was standing. At that point, SF left to run errands. SM later went to wake SC, only to find him unresponsive and with injuries. She attempted CPR and called SF, who immediately returned home. They drove SC to the ER and SM noted SF told her not to tell anyone he had been caring for SC. SM denied observing prior injuries, and gave a similar account as SF regarding discipline. SM reported having sustained physical abuse herself, by SF.

WCDSS contacted the DC and learned SC had no injuries when he was last there 3 days prior. It was the DC's practice to routinely check for injuries. SC had only been attending the DC for a few weeks. WCDSS obtained photographs of SC's injuries and spoke with collaterals who were able to speak to the appearance and age of the injuries in their professional capacities.

WCDSS learned SF had a 9yo CH by another woman. SF reported he occasionally visited him, the last time being at SF's home a few weeks prior to the report. Despite extensive efforts, WCDSS was unable to contact SS's BM until 5/9/18. Once contacted, SS's BM refused access to him, citing not wanting to expose him to the trauma. WCDSS informed her of the concerns.

SF was also listed as a subject on a CPS report in Bronx County on 4/17/18, with a different family composition. The report alleged he was extremely violent with a criminal history, having engaged in physical disputes with a CH's mother in the CH's presence. WCDSS contacted that mother as a collateral contact in the fatality investigation, and learned she believed SF suffered from anger issues. She disclosed the 2 of them used to frequently get into physical altercations. She reported SF contacted her on 4/16/18 around 9:30pm, stating his son was dead, and then threatened her and her son. WCDSS gathered an array of information pertaining to CPS concerns. She had no other relevant information about the fatality.

WCDSS completed a thorough investigation into the fatality, and closed the case as IND.

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was reviewed by the Westchester County Child Fatality Review Team on 4/30/2018.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046601 - Deceased Child, Male, 2 Yrs	046603 - Father, Male, 34 Year(s)	Lacerations / Bruises / Welts	Substantiated
046601 - Deceased Child, Male, 2 Yrs	046603 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
046601 - Deceased Child, Male, 2 Yrs	046602 - Mother, Female, 25 Year(s)	Lacerations / Bruises / Welts	Substantiated
046601 - Deceased Child, Male, 2 Yrs	046602 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated
046601 - Deceased Child, Male, 2 Yrs	046602 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
046601 - Deceased Child, Male, 2 Yrs	046603 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
046601 - Deceased Child, Male, 2 Yrs	046603 - 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:
WCDSS made diligent efforts to see SS face-to-face and interview him, but were unable to do so.

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 safety 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:
Not all referred services were refused, but it was not apparent that any services (aside from assistance with Victim's Advocacy Services) were utilized while the case was open.

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?

☐ Family Court ☒ Criminal Court ☒ Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
04/17/2018	Subject Father	Unknown	Pending
Comments:	SF was arrested for charges related to circumstances of the fatality. Criminal investigation and court process remained ongoing.		

Have any Orders of Protection been issued? Yes	
From: 04/17/2018	**To:** 04/18/2019
Explain: OCFS review of all CPS records revealed there were 2 OPs against SF issued after the fatality. One was to protect SM. The other was issued in a jurisdiction outside of Westchester County, to protect the other adult female whom SF had threatened on the day of the fatality. It was not documented that any children were named in any OPs.	

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Victim's Advocacy 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? No
Explain:
There was one half-sibling identified, whose BM refused access to him. His BM shared he had no knowledge of the fatality and did not intend on informing him; therefore, no service needs were identified for the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Victim Advocacy Services were referred to SM and were actively trying to engage her. Bereavement services were offered as well, though it was unknown if any services were used while the case was open.

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS history found for the SC, alleged subjects, or SS.

Known CPS History Outside of NYS

There was 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

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