Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-23-006

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

Issue Date: Jun 27, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 8 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 01/30/2023
Initial Date OCFS Notified: 01/30/2023

Presenting Information

An SCR report alleged on 1/22/23, the father shook the 8-month-old child and as a result, the child went into cardiac arrest. The child was revived at the home and was hospitalized. As a result of the abuse, the child experienced prolonged cardiac arrest, a brain injury with encephalopathy and an acute spinal subdural hematoma. On 1/30/23, the child died as result of the incident. At the time of the child's death, there was an open CPS investigation that began on 1/22/23 as a report was made to the SCR alleging the father shook the child in an effort to stop the child from crying. As a result of the shaking, the child became unconscious and stopped breathing. The child was in critical condition and had a pulse. The child was intubated and was unable to breathe independently.

Executive Summary

This fatality report concerns the death of the 8-month-old child that occurred on 1/30/23. A report was made to the SCR on the same day. At the time of the death, there was an open CPS investigation regarding the fatal incident that occurred on 1/22/23. The initial SCR report was made after the father shook the child in a violent manner, causing the child to become unconscious and limp. As a result of the father’s actions, the child was declared deceased on 1/30/23. At the time of his death, the child resided with the parents, twin sibling and 4-year-old sibling. The siblings were assessed to be safe with the maternal grandmother and the mother.

Onondaga County Department of Children and Family Services (OCDCFS) coordinated investigative efforts with law enforcement upon receipt of the initial SCR report. An autopsy was performed, and the cause of death was closed head trauma; the manner of death was homicide. The father was charged with Endangering the Welfare of a Child and Reckless Endangerment of a Child. Law enforcement anticipated also charging the father with manslaughter.

The father told law enforcement that he shook the child, and the child became unresponsive. The father called 911 and EMS responded and transported to the child to the hospital where he was placed on life-support. The 911 recording was obtained, and the father stated he shook the child, resulting in the child becoming unconscious.

At the time of the fatal incident, the father was caring for the twins while the mother worked. The 4-year-old sibling was visiting the maternal grandmother. The mother did not believe the father would intentionally hurt the children.

OCDCFS gathered information from collateral contacts including hospital staff and records, law enforcement officers and their records as well as family members. Prior to the death, there were no concerns for the care the father provided to the children. Concerns were revealed that the mother drank alcohol in excess, and she was offered a referral, that she accepted.

During the investigation, information was obtained that the father was released from jail and was out on bail. OCDCFS immediately made a safety plan with the mother to not allow the father around her or the siblings. As a result of the father’s release, OCDCFS filed an abuse petition on behalf of the siblings and a full stay-away order of protection was granted against the father regarding the siblings and the mother. At the time this report was written, the abuse petition remained pending.

The father was offered bereavement services and parenting classes; however, declined the referrals. The mother was offered bereavement services, mental health counseling, and an addiction services referral. The mother was offered a

referral for victims of DV as there were concerns regarding the father using physical violence toward the mother.

OCDCFS added and substantiated the allegation of IG against the father regarding the siblings. The allegations of IG, CHTS and DOA/Fatality were appropriately determined. The investigation revealed the father shook the child until he became unconscious and subsequently passed away due to his injuries. The siblings were derivatively abused. A Preventive Services Case was opened and court proceedings were ongoing.

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:
The allegations were appropriately determined.

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.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 01/30/2023 **Time of Death:** 01:30 PM

Date of fatal incident, if different than date of death: 01/22/2023
Time of fatal incident, if different than time of death: 12:00 PM

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ 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	8 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Month(s)

LDSS Response

On 1/30/23, OCDCFS received the fatality report from the SCR. The report was received during an open investigation that began on 1/22/23 regarding the SF shaking the SC and as a result, the SC became unresponsive. During the investigation regarding the fatal incident, OCDCFS coordinated investigative efforts with law enforcement, gathered information from collateral contacts, the parents and family members. The BM and SSs began residing with the MGM. The BM and the MGM agreed to a safety plan, barring contact between the SF and the SSs. The SSs were assessed to be safe in the care of the BM and MGM.

On 1/22/23, OCDCFS and LE interviewed the BM at the hospital. The BM said that morning she took the 4-year-old SS to visit the MGM, leaving the twins in the care of the SF. The BM went to work around 8:00 AM and around 12:00 PM, she received a call from the SF saying that something was wrong with the SC. The parents connected through a video call and the BM observed the SC laying on the bed and not moving. She instructed the SF to call 911 and she went to the home, at which time EMS was leaving. Hospital staff informed the BM that the SC had a brain bleed and went without oxygen for 30 minutes. The injuries were caused by trauma. The BM said it was typical for the SF to “jostle” the twins side-to-side

when they were fussy, which would calm them. According to the BM, the SF told her that he placed the SC on the bed, heard the SC cry and it sounded like he took 2 deep breaths before he became still and unresponsive.

LE shared information with OCDCFS that when the SF called 911, he reported that he shook the SC and laid him on the bed. LE said the SC was in a coma from a brain injury and his prognosis was poor. According to the SF, after bouncing and swaying the SC to stop him from crying, the SF violently shook the SC. The SF was arrested for Endangering the Welfare of a Child and Reckless Assault of a Child. The SF was expected to be charged with manslaughter, should the SC die. The BM said the SF would oftentimes shake and twist the twins, and they would smile and laugh.

OCDCFS contacted the SF via phone as well as interviewed in the jail. The SF initially denied shaking the SC, but then said the SC was screaming and after attempting to soothe him to no avail, the SC was convulsing; the SF attempted to perform CPR. The SF was informed of and agreed to the safety plan. The SF reported the BM drank alcohol every day.

On 1/24/22, the SSs were assessed to be safe in the care of the MGM. The MGM said the 4yo SS reported DV between the parents; however, he later recanted his statement. When interviewed, the 4yo SS said he did not feel safe with his parents but did not elaborate. He denied the SF ever hurt the twins, but said the SF hurt the BM by throwing a bottle at her.

On 1/30/23, hospital staff informed OCDCFS the SC had died. Hospital records noted the SC was cold to the touch upon his arrival and had several inflicted internal injuries.

The BM and MA were interviewed at the home. The MA expressed concerns for DV. The BM denied DV. The BM denied excessively drinking; but the MA said the BM drank to cope with the death. The BM was offered and accepted addiction treatment referrals.

After completing all casework requirements, the investigation was appropriately determined and closed. The Preventive Services Case remained open as the abuse petition remained pending in family court. Due to an order of protection, the SF was barred from contact with the family.

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 referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The death was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064035 - Deceased Child, Male, 8 Mons	064039 - Father, Male, 28 Year(s)	DOA / Fatality	Substantiated
064035 - Deceased Child, Male, 8 Mons	064039 - Father, Male, 28 Year(s)	Choking / Twisting / Shaking	Substantiated

064035 - Deceased Child, Male, 8 Mons	064039 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
064036 - Sibling, Male, 4 Year(s)	064039 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
064037 - Sibling, Male, 8 Month(s)	064039 - Father, Male, 28 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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other	☒	☐	☐	☐

children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: The mother accepted preventive services.				

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐
Explain as necessary: The siblings did not need to be removed as a result of the 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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
04/21/2023	There was not a fact finding	There was not a disposition
Respondent:	064039 Father Male 28 Year(s)	
Comments:	An abuse petition was filed against the father on behalf of the children as a result of the fatality. At the time this report was written, the family court proceedings were ongoing.	

Criminal Charge: Endangering the welfare of a child		**Degree:** NA	
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
01/25/2023	The father	Pending	Unknown
Comments:	The father was charged with Endangering the Welfare of a Child, a class A misdemeanor.		

Criminal Charge: Reckless assault of a child		**Degree:** NA	
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
01/25/2023	The father	Unknown	Unknown
Comments:	The father was charged with Reckless Assault of a Child, a class D felony.		

Have any Orders of Protection been issued? Yes	
From: 04/21/2023	**To:** Unknown
Explain: The record reflected an order of protection was granted against the father on behalf of the mother and children. The father was barred from any contact with the mother or children.	

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:
The father declined bereavement services and parenting classes. The mother accepted preventive services, bereavement counseling, DV advocacy and addiction 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:
A referral was made for bereavement services with regard to the 4-year-old sibling. It remained unknown if the service was utilized.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother accepted bereavement services, victim's support services, preventive services and addiction services. The father declined bereavement services and parenting classes.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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

8/31/18- 10/9/18 The BM was unsubstantiated for IG and PD/AM regarding the 4yo SS.

10/23/18- 11/3/18 The SF was unsubstantiated for IG regarding the 4yo SS.

8/13/19- 10/22/19 The BM was substantiated for IG and unsubstantiated for PD/AM of the 4yo SS.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Legal History Within Three Years Prior to the Fatality

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

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