Child Fatality Report

Report Identification Number: NY-22-108

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

Issue Date: Jun 12, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/26/2022
Initial Date OCFS Notified: 12/20/2022

Presenting Information

New York City Administration for Children's Services (ACS) received an SCR report dated 12/27/22 regarding the death of the 4-month-old male subject child. The report alleged on 12/20/22, the SF left the SC on the bed while he went outside to smoke a cigarette. When he returned, he found the SC on the floor, unresponsive, and frothing at the mouth. The SF called EMS and the SC was transported to the hospital. The SC was diagnosed with bilateral retinal hemorrhage, a right-side clavicle fracture, bilateral subdural hematomas, lack of oxygen to the brain, Shaken Baby Syndrome, and abusive head trauma. The SC sustained the injuries as a result of the SF shaking the SC. The SC was placed on life support and declared brain dead on 12/26/22. The SC was removed from life support and was declared deceased at 6:01PM on 12/26/22. The father admitted to shaking the SC and was criminally charged. The role of the mother was unknown.

Executive Summary

This fatality report concerns the death of a 4-month-old male subject child that occurred on 12/26/22. At the time of the child's death, he resided with his father. The mother did not reside in the home; however, she saw the child daily. There were no surviving siblings.

ACS collaborated investigative efforts with law enforcement regarding the death. The father called 911, after finding the child unresponsive on 12/20/22. EMS arrived at the home and initiated CPR, the child regained a pulse and was transported to the hospital. The child was intubated and placed on life support. Hospital staff noted concerns the child had injuries consistent with non-accidental trauma. A comprehensive evaluation was completed on the child and he had bilateral subdural hematomas, global hypoxic ischemic encephalopathy, a right side distal clavicle fracture, and bilateral multilayered retinal hemorrhages consistent with Shaken Baby Syndrome. The child was transferred to another hospital for a higher level of care. According to hospital staff, the child had a brain test done and the results were consistent with brain death. A second brain test was completed on 12/26/22, and there was no change; the child was taken off life support, went into cardiac arrest, and was declared deceased at 6:01PM.

The medical examiner was notified and performed an autopsy. The final autopsy report was pending at the time this report was written. The record reflected ACS spoke to the medical examiner and the cause of death was inflicted injury and the death was ruled a homicide. The father was interviewed by law enforcement and admitted to shaking the baby prior to calling 911. Law enforcement arrested the father, and he was charged with Manslaughter 2nd, Reckless Assault of a Child 2nd degree, Reckless Endangerment 2nd degree, Assault 3rd degree, and Endangering the Welfare of a Child. The criminal case was pending in criminal court at the time the CPS investigation was closed, and the father remained incarcerated.

ACS offered the mother bereavement services, mental health counseling and burial assistance, which she declined. The record did not reflect ACS offered the father services. ACS substantiated the allegations of DOA/Fatality, Choking/Twisting/Shaking, Fractures, Inadequate Guardianship, and Internal Injuries against the father regarding the child. ACS found a fair preponderance of evidence that the father's actions caused the injury that led to the child's death. The CPS investigation was indicated and closed on 2/8/23.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will

identify action(s) ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** 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:
ACS made an appropriate determination based on the evidence obtained throughout the investigation.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was not commensurate with the case circumstances, as the record did not reflect the father was interviewed despite being the alleged subject.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The record did not reflect the subject father was interviewed regarding the allegations in the report. The record did not provide information as to why the subject father could not be interviewed by ACS.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.
Issue:	Failure to produce records upon OCFS request
Summary:	On 4/19/23, 4/24/23, and 4/27/23 OCFS requested documents from ACS external case record

	regarding the fatality. The documents requested were not received from ACS.
Legal Reference:	18 NYCRR 428.10 (a)
Action:	Records, whether maintained by a district or provider agency pursuant to a purchase of service agreement, must be available at all reasonable times for inspection by representatives of OCFS, and photostatic copies of such records must be forwarded to OCFS upon request.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/26/2022 **Time of Death:** 06:01 PM

Date of fatal incident, if different than date of death: 12/20/2022
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 01:32 AM
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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Other Household 1	Mother	No Role	Female	19 Year(s)

LDSS Response

On 12/27/22, ACS received a report regarding the death of the SC. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the source of the report and completed a CPS history check regarding the family. ACS contacted LE, the DA and the medical examiner. ACS interviewed the mother regarding the events that led up to the SC's death.

ACS learned that the mother moved out of the father's home on 12/6/22, and went to stay at a shelter. The mother and father were arguing a lot and she felt it would be better for the SC if she got her own apartment. The mother was on a waiting list for an apartment for her and the SC. The mother felt it was best to leave the SC with the father because she was staying at the shelter and attended school during the day. The mother reported she never saw the father be aggressive with the child and had no concerns for the father caring for the child. The mother spent time with the SC daily at the father's residence and attended the SC's medical and visiting nurse appointments. The mother reported she last saw the SC on 12/19/22, when she went to the father's home to breastfeed the SC and spend time with him. The mother reported the SC acted normal and she left the home around 6:15PM to return to the shelter. The mother had no concerns for the SC when she left. The father called the mother on 12/20/22 at about 7:20AM, and said the SC was at the hospital, after he found the SC on the floor, in a ball, foaming at the mouth. While the father remained incarcerated throughout the CPS investigation, the record did not reflect the father was interviewed by ACS regarding the SC's death or offered any services. Law enforcement interviewed the father; however, there was no documentation in the record regarding the outcome of the interview. The record did not reflect a reason why ACS could not interview the father regarding the death of the SC.

ACS contacted collateral sources, including relatives, the pediatrician, hospital staff, law enforcement, and visiting nurses. The SC was up to date with well child visits, immunizations, and was last seen at the pediatrician on 12/7/22, with no concerns noted. The visiting nurses were last in the home on 12/13/22 and had no concerns. At the close of the investigation, the mother was engaged in counseling and had an identified support system in place. ACS offered additional community-based referrals if needed. The father remained incarcerated at the close of the investigation, and the criminal case was ongoing in criminal court. ACS found evidence to support the allegations in the report, and appropriately indicated and closed the case.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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? No
Comments: New York City Administration for Children's Services does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063448 - Deceased Child, Male, 4 Mons	063450 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
063448 - Deceased Child, Male, 4 Mons	063450 - Father, Male, 25 Year(s)	Choking / Twisting / Shaking	Substantiated
063448 - Deceased Child, Male, 4 Mons	063450 - Father, Male, 25 Year(s)	Fractures	Substantiated
063448 - Deceased Child, Male, 4 Mons	063450 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated

063448 - Deceased Child, Male, 4 Mons	063450 - Father, Male, 25 Year(s)	Internal Injuries	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:
The record did not reflect that ACS interviewed the father or reviewed the interview that was completed by law enforcement with the father.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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: Manslaughter **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Unknown	The father	Pending	The case is still pending in criminal court.

Comments:	The father was charged with Manslaughter 2nd degree, Reckless Assault Of a Child 2nd degree, Reckless Endangerment 2nd degree, Assault 3rd degree, and Endangering the Welfare of a Child. The case was still pending in criminal court at the time this report was written.

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:
Services were offered to the mother, and she declined. The mother was already engaged with services through the shelter. Despite the mother expressing previous DV concerns, no services specific to this need were offered/explored. The record did not reflect ACS offered the father 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? N/A
Explain:
There were no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

ACS offered the mother bereavement counseling and burial assistance, and she declined. Although the father was incarcerated, the record did not reflect ACS offered the father services.

History Prior to the Fatality

Child Information

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/20/2022	Deceased Child, Male, 4 Months	Father, Male, 25 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 4 Months	Father, Male, 25 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The father was the sole caretaker to the 4-month-old SC. Between 12/17/22 and 12/18/22, the SC had difficulty swallowing and was full of mucus and the father failed to seek medical care for the SC. On 12/20/22, the SC's symptoms continued; the SC had saliva bubbling from his mouth, and he had lost consciousness. The SC was hospitalized, intubated, did not have any brain activity, and was at risk of death. The mother had an unknown role.

Report Determination: Indicated | **Date of Determination:** 02/08/2023

Basis for Determination:
ACS found a fair preponderance of evidence to substantiate the allegation of IG against the father regarding the SC. The father admitted to shaking the SC and as a result the SC passed away. The death was ruled a homicide and the father was arrested and criminally charged, and he remained incarcerated at the close of the investigation. The allegation of LMC was unsubstantiated against the father regarding the SC. ACS found the SC received regular medical care.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed

timely. Written notice was provided timely, and a CPS history check was completed. The mother was seen and interviewed. The father was interviewed by law enforcement; however, the record did not reflect ACS saw or spoke with the father regarding the report.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
Although the SF was interviewed by LE, the record did not reflect the SF was interviewed by ACS regarding the SCR report or that ACS reviewed the interview done by LE with the SF. The SF was the alleged subject, and the record reflected ACS was aware of the location where he was incarcerated.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

[redacted]

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

ACS sent an out-of-state inquiry request to North Carolina and South Carolina regarding the mother and father. There was no substantiated CPS history for the mother or the father.

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