Child Fatality Report

Report Identification Number: RO-22-018

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

Issue Date: Nov 28, 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	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: 2 month(s)
Jurisdiction: Livingston
Gender: Male
Date of Death: 06/16/2022
Initial Date OCFS Notified: 06/16/2022

Presenting Information

An SCR report was received which alleged that on 6/9/22, the father found the two-month-old subject child unresponsive in his car seat, bleeding from the mouth and nose. The child was last seen responsive that morning by the father when he put the child down for a nap. The father called the mother and then 911. The child was transported to the hospital and admitted. He was initially diagnosed with hypoxic ischemic encephalopathy due to a brain injury. Additional diagnoses were dense sub-retinal hemorrhages in both eyes and retinoschisis in the left eye. These injuries were sustained while in the sole care of the father and there was no explanation for how they were sustained. The role of the mother was unknown.

Executive Summary

This fatality report concerns the death of a two-month-old male subject child that occurred on 6/16/22. A report was registered with the SCR on that same date with allegations of Fractures, Internal Injuries, Inadequate Guardianship, Swelling/Dislocations/Sprains, and DOA/Fatality against the child's father. Livingston County Department of Social Services (LCDSS) received the report and investigated the child's death. LCDSS had been involved with the family since 6/9/22, after the subject child was found unresponsive while in the care of the father and admitted to the pediatric intensive care unit where he remained until his death. An autopsy was completed; however, the official cause and manner of death had not yet been released at the time of this writing. Through conversations with law enforcement and the medical examiner, it was learned the child had sustained and died from numerous serious injuries consistent with physical abuse.

At the time of the child's death, he resided with his mother and father. There were no surviving siblings or other children in the household. The investigation revealed that on 6/9/22, the father was the sole caretaker of the subject child as the mother was not at home. At an unknown time that day, the child became fussy, and the father became increasingly frustrated with the child as a result. The mother received a call from the father at approximately 3:40PM informing her that he had fastened the subject child in his car seat too tightly, and the subject child appeared to be dead. The mother told the father to contact emergency services, and when she arrived back at the home, first responders were inside with the child. The child regained a pulse and was brought via ambulance to the hospital where he was placed on life support with a poor prognosis. It was later revealed that the father had inflicted the fatal injuries to the child by throwing, strangling, and shaking him. The child succumbed to his injuries at 2:36PM on 6/16/22.

Throughout the investigation, LCDSS spoke with collateral sources which included law enforcement, the child's pediatrician, hospital staff, and family members. The father was arrested and charged with murder in the 2nd degree, manslaughter in the 1st and 2nd degrees, and endangering the welfare of a child; the mother was not charged. LCDSS was unable to interview the father due to retaining counsel. LCDSS offered the mother services in response to the fatality, but she declined as she already established a mental health counselor through the hospital. The allegations against the father were substantiated and the investigation was closed.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

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:
LCDSS gathered sufficient information to appropriately determine the allegations. There were no surviving siblings or other children in the household.

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 reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Approximately half of the progress notes were entered more than one month past their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	LCDSS will enter progress notes contemporaneously as events occur.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/16/2022 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 06/09/2022
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Livingston
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 alcohol or drugs? N/A
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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	No Role	Female	23 Year(s)

LDSS Response

On 6/9/22, LCDSS and LE met at the hospital and spoke with medical staff. At that time, SC was still alive and on a ventilator. The treating physician reported SC's injuries were suspicious in nature and SC was being transferred to the PICU. LCDSS interviewed BM without LE present. BM reported that on 6/9/22, she received a call from SF around 4:00PM and he told her she needed to come home because SC was dead. BM said she asked SF what happened, and he informed her he and SC were preparing to go visit a family member, so he had put SC in his car seat. He then told her he turned around to do something, and when he looked back at SC there was blood coming from his mouth. BM stated she told SF to call 911 and when she was almost home, SF called again asking where she was as EMS had arrived. BM stated when she finally got there, SF was in the driveway and the paramedics were inside the house. She said SF was blaming himself and said he fastened SC in the car seat too tightly. BM said she rode in the ambulance with SC to the hospital and SF stayed at the home with LE.

On 6/9/22, LE informed LCDSS that SF was arrested and charged with reckless assault; however, he had posted bond and was released. LE reported a full stay away OOP was issued against SF protecting SC, and he was not allowed at the hospital.

On 6/13/22, LCDSS spoke with medical staff who explained SC was critically ill with "catastrophic injuries" and

diagnosed with the following: anoxic brain injury, acute respiratory failure, subdural bleeding with sheering of bridging veins, parietal skull fracture, hypercarbic respiratory failure, hyperglycemia, transaminitis, cardiac arrest and child abuse. The record noted SC failed two brain death tests, and on 6/17/22, there was a note entered about SC undergoing an autopsy. The record did not reflect any additional information surrounding the time of death, or what transpired in the hours leading up to SC's death.

Following SF's arrest, he retained an attorney and was advised not to speak with LCDSS. LE reported SF at first had several different stories as to what happened to SC, including what he had told BM involving a car seat. LE explained that eventually, SF admitted to inflicting the injuries. LE provided LCDSS with SF's deposition and it noted that on 6/9/22, SC was fussy which had caused SF to become frustrated. SF reported to LE that in response, he threw SC headfirst into his crib headboard, choked him and heard "at least two" bones break, shook SC, threw him onto the floor and then "jerked him upright" by his feet. On 6/17/22, LCDSS spoke with the ME who reported the findings of the autopsy were consistent with the alleged abuse.

The case record noted LCDSS spoke with SC's pediatrician who reported no concerns regarding SC's care prior to the fatal incident. The pediatrician stated he had seen SC "a couple of days" prior to his death, and he was healthy. Through conversations with BM and MGM, it was learned there were no previous concerns regarding SF's care of SC, and he had never shown any violent tendencies in the past. LCDSS filed an Article 10 severe abuse petition; however, the date on which this was filed was not noted. BM was engaged in mental health counseling by the close of the investigation, and there were no criminal charges brought against her for the death of SC. SF was indicted on murder in the 2nd degree, manslaughter in the 1st and 2nd degree, and endangering the welfare of a child. LCDSS found a fair preponderance of evidence to substantiate all the allegations against SF and indicated and closed the investigation.

Official Manner and Cause of Death

Official Manner: Pending
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)?No
Comments: Livingston County adhered to previously approved protocols for joint investigation.

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: Livingston County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062106 - Deceased Child, Male, 2 Mons	062108 - Father, Male, 27 Year(s)	DOA / Fatality	Substantiated
062106 - Deceased Child, Male, 2 Mons	062108 - Father, Male, 27 Year(s)	Fractures	Substantiated
062106 - Deceased Child, Male, 2 Mons	062108 - Father, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
062106 - Deceased Child, Male, 2 Mons	062108 - Father, Male, 27 Year(s)	Internal Injuries	Substantiated

062106 - Deceased Child, Male, 2 Mons	062108 - Father, Male, 27 Year(s)	Swelling / Dislocations / Sprains	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
LCDSS was unable to interview the father due to advice from his attorney. Approximately half of the progress notes were entered more than one month past their event dates.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

	There was not a fact finding	There was not a disposition
Respondent:	062108 Father Male 27 Year(s)	
Comments:	The record noted a severe abuse petition was filed against the father; however, the date it was filed or any following court dates were not documented.	

Criminal Charge: Murder	**Degree:** 2		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Subject Father	Unknown	Pending
Comments:	The father was charged with murder in the 2nd degree, manslaughter in the 1st and 2nd degrees, and endangering the welfare of a child.		

Criminal Charge: Manslaughter	**Degree:** 1		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Subject Father	Unknown	Pending
Comments:	The father was charged with murder in the 2nd degree, manslaughter in the 1st and 2nd degrees, and endangering the welfare of a child.		

Criminal Charge: Manslaughter	**Degree:** 2		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Subject Father	Unknown	Pending
Comments:	The father was charged with murder in the 2nd degree, manslaughter in the 1st and 2nd degrees, and endangering the welfare of a child.		

Criminal Charge: Endangering the welfare of a child	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Subject Father	Unknown	Pending
Comments:	The father was charged with murder in the 2nd degree, manslaughter in the 1st and 2nd degrees, and endangering the welfare of a child.		

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: LCDSS offered the mother services in response to the death of the subject child.							

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 or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
LCDSS offered the mother services in response to the fatality.

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? N/A
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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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