Child Fatality Report

Report Identification Number: BU-20-026

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

Issue Date: Feb 25, 2021

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 09/19/2020
Initial Date OCFS Notified: 09/19/2020

Presenting Information

An SCR report was received with concerns that the one-year-old subject child died on 9/19/20 after she was beaten by the mother's boyfriend on 9/16/20. The child sustained a massive brain injury and was placed in an induced coma. The child died of bilateral subdural hemorrhaging.

Executive Summary

This fatality report concerns the death of a one-year-old female subject child that occurred on 9/19/20. A report was made to the SCR on 9/19/20 with allegations of Inadequate Guardianship, Swelling/Dislocations/Sprains, Internal Injuries, Lack of Medical Care and DOA/Fatality against the child's mother and her boyfriend (parent substitute). Erie County Department of Social Services (ECDSS) received the report and completed a thorough investigation into the child's death. An autopsy was completed, and the cause of death was noted as blunt impact injuries of the head. The manner of death was homicide.

At the time of the child's death, she resided with her mother. The parent substitute did not live in the home; however, stayed there frequently. The parent substitute had a six-year-old daughter who resided with her mother. The mother had an adult daughter, and a 14-year-old son who was in the custody of his biological father, and whom she had no contact with since 2009. The subject child's biological father was unknown, and there were no other children living in the household. The investigation revealed on the night of 9/15/20, the mother was at work, and the parent substitute was caring for the child at the mother's house. The mother returned home at approximately 10:00PM to find blood on a pillow, and the child asleep. The parent substitute told the mother the child was playing atop plastic bins and had fallen off them earlier in the night, which he felt caused the child to have a seizure. Neither the parent substitute nor the mother called emergency services and did not seek medical care for the child until 11:30PM, when they drove her to the hospital. The child was immediately admitted and underwent emergency surgery for a brain hemorrhage. Medical staff noted the child's injuries as multiple contusions throughout her body, bilateral retinal hemorrhages, bilateral and subdural hematomas, and subdural abnormalities of the brain. The injuries were determined to be non-accidental trauma and not consistent with a fall. The child succumbed to her injuries and was declared brain dead on 9/19/20. The child was removed from life support and pronounced deceased shortly thereafter.

The parent substitute was interviewed by law enforcement and admitted to repeatedly shaking, dropping, and hitting the child over a six week period. The parent substitute was arrested and charged with first degree manslaughter and second-degree murder. There were no criminal charges brought against the mother.

From the time the investigation began to the time of its closure, ECDSS met with family members and spoke with numerous collateral sources, including hospital staff, neighbors, law enforcement, and the medical examiner. Services were offered to address grief and bereavement. ECDSS found evidence that parent substitute's actions and the mother's inaction ultimately led to the child's death, and therefore, the report was indicated and closed.

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:
ECDSS gathered information to 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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/19/2020 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 09/16/2020
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Erie
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? Unable to determine

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	Female	1 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Other Household 1	Mother's Partner	Alleged Perpetrator	Male	35 Year(s)

LDSS Response

On 9/19/20, ECDSS received the fatality report. This report was subsequent to an open CPS investigation received on 9/16/20, after SC was hospitalized with injuries. ECDSS had been involved with the family since April 2019, after a services case was opened following SC's birth. At that time, SC was removed from SM's care and briefly placed with a relative due to SM's history of drug use and having lost custody of her other two CHN several years prior. Upon receipt of the initial report, ECDSS initiated their investigation promptly and coordinated their efforts with their MDT.

On 9/17/20, ECDSS met with SM at the hospital while SC was still alive. SM reported PS did not reside in her home; however, he did spend the night often. SM said she had recently started a new job, and PS would care for SC while she worked. SM stated on the morning of 9/16/20, she awoke, gave SC a bottle, and left for work while PS watched SC at her home; everything was "normal." SM explained she went home on her lunch break and had lunch with SC. SC appeared tired but seemed fine otherwise. SM returned to work and did not get home until around 10:00PM. SM said when she arrived home, she saw a pillow on the floor with blood on it; PS told her SC had fallen off bins earlier, then had a seizure. SM denied PS called her regarding the incident. SM said SC was responsive and breathing normally, so she did not feel it was an emergency. SM stated she called SC's doctor, and they told her to bring SC to the hospital, so she and PS did so. SM reported once at the hospital, SC was taken into surgery for brain hemorrhaging. SM denied ever witnessing PS harm SC and had no concerns about him prior to this.

On 9/18/20, ECDSS spoke with a neighbor (OA) who witnessed SC in distress. OA explained on the evening of 9/16/20, PS knocked on her door, and said something was wrong with SC. OA went downstairs and saw SC laying on the floor, and she advised PS to call 911. OA stated PS refused, so she called and texted SM but got no response. OA said PS insisted SC had a seizure and was fine. OA went upstairs, and a while later, PS asked her to check on SC again. OA said she saw SC in the same place as before, and she looked stiff; she did not observe her moving. OA again told PS to call 911 and he refused. OA stated SM returned home around 10:00PM, so she went downstairs to speak to her. She said SC was still in the same position, and PS and SM were trying to wake her up. She had no further information surrounding the incident and denied witnessing anyone harm SC in the past.

On 9/19/20, SC was declared brain dead and removed from life saving measures. SC died soon after.

On 9/21/20, ECDSS interviewed PS via video conference. PS reported on 9/16/20, around 7:00PM, he was babysitting SC and had been playing a video game when he heard a loud "boom." PS stated SC had been playing on a tote bin and had

fallen off it; he found her laying beside it making a wheezing sound. PS stated he thought SC had a seizure, so he laid her on her side and put a pillow under her head. PS said he gave SC a bottle and thought she was fine. He reported he asked OA to check on SC, and SC was still breathing and moving at that time. PS stated SM arrived home at 10:00PM, and at 11:30PM, they took SC to the hospital. PS denied he ever hit SC at any time and denied having any further information surrounding the incident.

Throughout the investigation, ECDSS conducted follow-up interviews with SM and OA, as well as spoke with many collateral sources. PS's CH was interviewed, and that CH was assessed as safe. LE informed ECDSS that PS admitted to hitting, dropping, and shaking SC on numerous occasions since July 2020. He was arrested and charged with 1st degree manslaughter and 2nd degree murder. Due to information obtained by LE, as well as SM's failure to contact emergency services when SC was in distress, ECDSS substantiated the allegations against SM and PS, and the case was closed.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: This fatality investigation was conducted by the Erie County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Erie County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056329 - Deceased Child, Female, 1 Yrs	056330 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
056329 - Deceased Child, Female, 1 Yrs	056330 - Mother, Female, 38 Year(s)	Lack of Medical Care	Substantiated
056329 - Deceased Child, Female, 1 Yrs	056331 - Mother's Partner, Male, 35 Year(s)	DOA / Fatality	Substantiated
056329 - Deceased Child, Female, 1 Yrs	056331 - Mother's Partner, Male, 35 Year(s)	Internal Injuries	Substantiated
056329 - Deceased Child, Female, 1 Yrs	056331 - Mother's Partner, Male, 35 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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ECDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/16/2020	PS	Pending	Unknown
Comments:	PS was charged with first degree manslaughter and second degree murder regarding the death of SC.		

Criminal Charge: Manslaughter **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/16/2020	PS	Pending	Unknown
Comments:	PS was charged with first degree manslaughter and second degree murder regarding the death of SC.		

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:
ECDSS provided SM with referrals and information surrounding grief and bereavement counseling. SM was receiving services through an open preventive case at the time of the fatality, and the case remained open following SC's death for additional support.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief and bereavement services were offered to SM. SM was also involved in an open services case at the time of SC's death.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was the child ever placed outside of the home prior to the death?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
Was the child acutely ill during the two weeks before death?	No

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)
11/16/2019	Deceased Child, Female, 7 Months	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 7 Months	Mother, Female, 37 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 7 Months	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 7 Months	Mother, Female, 37 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SM was involved in a physical altercation with a neighbor while holding SC, and intentionally dropped SC on the ground during such. There were further concerns SM had dropped SC on her head out of anger in the past, and SM was using drugs. The report alleged SM was allowing strange men in and out of the home while SC was present.

Report Determination: Unfounded | **Date of Determination:** 01/31/2020

Basis for Determination:
Family members and collateral sources were interviewed, including SC's daycare, LE, services case manager, and medical staff. There were no concerns noted and LE reports indicated SM was the victim during the altercation. SM had recently been evaluated for substance abuse and treatment was not recommended. SM found new housing which was deemed appropriate. SM reported she was in a relationship with PS; however, he was not living with her and SC. SM was compliant with her court menu and service providers. The investigation was unfounded and closed.

OCFS Review Results:
This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/09/2019	Deceased Child, Female, 1 Days	Mother, Female, 36 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
This SCR report was received with concerns SM gave birth to SC, and SM was homeless. There were further concerns the mother had her 2 other children removed from her care due to neglect, and also had a history of drug abuse.

Report Determination: Indicated | **Date of Determination:** 05/13/2019

Basis for Determination:
ECDSS completed interviews and spoke with collateral sources, including medical staff and community resources. The

child was initially placed in 1017 custody with a relative until SM secured housing and attended substance abuse and mental health evaluations. SM completed what was required and the child was returned to her care. ECDSS found evidence SM did not have an appropriate plan for her child at the time of birth and indicated the allegations. A petition was filed and a mandated preventive services case was opened in response to this investigation.
OCFS Review Results: This investigation met all statutory requirements.
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

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

SM was listed as a subject in one indicated report from 2011, with allegations of IG and L/B/W regarding her now 18yo CH.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 04/17/2019

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine

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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Preventive Services History

A mandated preventive services case was opened on 4/17/19 after SC was removed from SM's care and placed in 1017 custody with a relative. The removal occurred because SM did not have a plan for SC following her birth; SM was homeless, lacked supplies, and used illicit substances during her pregnancy. There were further concerns SM lost custody of her two older CHN due to neglect, and she had not had contact with them since 2011. SM was ordered via family court to attend substance abuse and mental health evaluations, as well as secure stable housing. SM completed her evaluations and there were no recommendations for treatment. SM secured employment and found stable housing for herself and SC. SC was returned to SM's custody on 5/1/19. Preventive services remained open to further assist SM with gaining skills to appropriately care for SC. The case was open at the time of SC's death, with the last face to face contact with SM and SC occurring on 9/14/20; no safety concerns were noted for SC at that time. The services case was closed on 10/30/20, as there were no other CHN in SM's care.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to 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:**
04/10/2019	Adjudicated Neglected	Return to Guardian

Respondent:	056330 Mother Female 38 Year(s)
Comments:	Following SC's birth on 4/7/19, ECDSS removed SC on 4/10/19 and filed a neglect petition in family court on that same date. SC was placed in 1017 custody with a relative while SM secured housing and completed substance abuse and mental health evaluations. Upon completion, SC was returned to SM's care under an order of supervision on 5/1/20. ECDSS remained involved with the family through an open mandated preventive services case from 4/17/2019 until 10/30/20.

Additional Local District Comments

We at the Erie County Department of Social Services appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality or to the CPS investigations conducted during the three years preceding the fatality.

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