Child Fatality Report

Report Identification Number: NY-17-064

Prepared by: New York City Regional Office

Issue Date: Dec 22, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/23/2017
Initial Date OCFS Notified: 06/27/2017

Presenting Information

On 6/27/17, the SCR registered a report concerning the death of the SC.

The report stated that on 6/18/17, the father beat the SC while he was left alone with her in his home. The SC sustained multiple injuries, to her skull, bruising to her mouth, legs, and nose. When the mother arrived at the father's home to pick up the SC she found the child unresponsive. The mother attempted to leave the father's home with the SC, but he began to beat the mother. The report stated the mother and the SC were taken to Coney Island Hospital via ambulance where the SC remained in critical condition. The SC was brain dead and died from her injuries on 6/23/17, at 10:40 A.M.

Executive Summary

The one-year-old SC died on 6/23/17. The autopsy report listed the cause of death as abusive head trauma and the manner of death as homicide.

On 6/27/17, the SCR registered a report concerning the death of the SC. The allegations of the report were: DOA, XCP, LMC, L/B/W, II and IG of the SC by the father.

The 17 and 19-year-old parents were separated; each resided with their respective mothers (MGM and PGM) and family members. The SC was the parents' only child and lived with the mother at the MGM's home.

The family had an open investigation dated 6/18/17 concerning the incident that led to the SC's injuries. According to the parents, the mother dropped off the SC at the PGM's on 6/16/17 for a weekend visit with the father.

At the time of the incident leading to the SC's injuries, there was an active limited order of protection (OOP) that was issued on 7/28/16 against the father due to expire on 7/27/21. The documentation notes the OOP did not exclude contact between the SC and the father.

The mother said that on 6/18/17, she arrived at the father's home and found the SC with bruises lying unresponsive on the sofa. According to the mother, the father had not called for medical attention. The mother said she picked up the SC and ran down twelve flights of stairs for help. The mother said the father chased her and then began to physically assault her while she held the SC. The father then grabbed the SC from the mother and passed the child on to a stranger. The mother said the father continued to assault her until other strangers intervened. The father fled the scene before the EMS and the NYPD arrived.

The SC was transported to Coney Island Hospital, and later transferred to Maimonides Medical Center (MMC) for a higher level of care. The SC's prognosis was poor and he later died from his injuries.

On 6/19/17, the father was apprehended by the NYPD and indicted for murder. The father was remanded to the Riker's Island Correctional facility pending trial.

ACS interviewed the father who explained the SC fell off the bed while he was in the shower. However, medical staff concluded this explanation was not consistent with the SC's injuries. The father admitted to assaulting the mother, but did

not provide a plausible explanation. He insisted, that he had "blacked out."

ACS assessed the other children in both households and had no concerns for their safety. ACS completed safety assessments and the risk assessment profile in error as the parents had no other children.

On 8/18/17 and 8/25/17, ACS indicated the reports against the father. All the allegations were substantiated based on the SC's injuries and the information provided by medical staff, the ME and the NYPD.

PIP Requirement
There are no corrective actions for this report.

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:
N/A

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:
N/A

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

Child Fatality Report

Date of Death: 06/23/2017 **Time of Death:** 10:40 AM

Date of fatal incident, if different than date of death: 06/18/2017
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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	13 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	13 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	44 Year(s)
Deceased Child's Household	Mother	No Role	Female	17 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	2 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	6 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	11 Month(s)
Other Household 1	Aunt/Uncle	No Role	Male	6 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	17 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	11 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	19 Year(s)
Other Household 1	Grandparent	No Role	Female	37 Year(s)

LDSS Response

ACS investigated the fatality report simultaneously with the 6/18/17 open report.

According to ACS' investigation, the mother dropped off the SC at the PGM's home on 6/16/17 for a weekend visit. The mother said that on 6/18/17 the father left her a message indicating there was something wrong with the SC. When the mother walked in the PGM's home, she found the SC lying on the sofa with bruises and gasping for air. ACS interviewed the paternal relatives who resided in the home and confirmed the father was alone with the SC when she sustained the injuries.

The mother said the father had not sought medical care for the SC and attempted to stop her from doing so. The mother said she ran out of the home, but the father chased her and then physically assaulted her while she held the SC. Strangers intervened and called 911, but by the time the NYPD and EMS responded to the scene the father was gone. The mother was transported with the SC to Coney Island Hospital where they were both treated. The NYPD indicated the mother's face was swollen and she had a cut on her eye.

The SC sustained multiple organ failure and abusive head trauma. According to the medical staff, the SC had a fracture of the skull, specifically intracranial bleeds, subarachnoid, and an epidural hematoma. Due to the SC's prognosis, she was transferred to MMC. The SC was not expected to survive and remained on life support until 6/23/17.

According to the father, on 6/18/17 he left the SC asleep on the bed while he went to take a shower. The father said he heard a loud "bump" and thought the noise came from upstairs. The father said when he came out of the shower, he saw the SC on the floor. The father alleged the SC fell, but his explanation was not plausible per the child abuse specialist from MMC who determined the explanation was not consistent with the SC's injuries.

The father said he picked up the SC and noticed she was "throwing up through her nose and her eyes were rolling in the back of her head." The father said he did not call 911 because he did not want the police to think he hurt the SC. The father said he attempted to call the PGM and the mother, but the calls did not go through. The father left a message for the mother urging her to pick up the SC. The father admitted that he assaulted the mother because he "blacked out" when he saw her running out of his home with the SC.

The father was arrested on 6/19/17 and denied hurting the SC. The father was remanded to the Riker's Island Correctional Facility on 6/20/17. The ADA confirmed the father was indicted and charged with manslaughter and murder of the SC.

There was no documentation noting whether the father was under the influence of any substance at the time of the incident.

The SC's pediatrician reported the child was happy, healthy and well adjusted. The pediatrician had no concerns regarding the SC or parental care the child received in the mother's care.

The father resided with the PGM and extended relatives. The PGM declined bereavement services for her family. ACS had no safety concerns about these children.

The report notes the MGM accepted bereavement services as the mother was distraught about the SC's death.

ACS indicated the reports.

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)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039261 - Deceased Child, Female, 1 Yrs	042461 - Father, Male, 19 Year(s)	Swelling / Dislocations / Sprains	Substantiated
039261 - Deceased Child, Female, 1 Yrs	042461 - Father, Male, 19 Year(s)	Inadequate Guardianship	Substantiated
039261 - Deceased Child, Female, 1 Yrs	042461 - Father, Male, 19 Year(s)	Lacerations / Bruises / Welts	Substantiated
039261 - Deceased Child, Female, 1 Yrs	042461 - Father, Male, 19 Year(s)	Excessive Corporal Punishment	Substantiated
039261 - Deceased Child, Female, 1 Yrs	042461 - Father, Male, 19 Year(s)	Internal Injuries	Substantiated
039261 - Deceased Child, Female, 1 Yrs	042461 - Father, Male, 19 Year(s)	Lack of Medical Care	Substantiated
039261 - Deceased Child, Female, 1 Yrs	042461 - Father, Male, 19 Year(s)	DOA / Fatality	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:
N/A

Fatality Safety Assessment Activities

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

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:
There was no risk assessment needed as the parents had no surviving children. ACS completed the RAP although it was not required.

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:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Father	Pending	Pending
Comments:	The father was charged with the assault on the mother.		

Criminal Charge: Manslaughter **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**

Pending	Father	Pending	Pending
Comments:	The father was indicted for the manslaughter concerning the death of the SC.		

Have any Orders of Protection been issued? Yes	
From: 08/18/2017	**To:** Unknown
Explain: After the SC's death an OOP was issued against the father by KCFC on behalf of the mother.	

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: N/A							

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. There was no immediate need for services for other children in the household as a result of the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There was no immediate need for service as a result of the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	N/A
Was the child acutely ill during the two weeks before death?	Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/18/2017	Deceased Child, Male, 1 Years	Father, Male, 19 Years	Inadequate Guardianship	Indicated	Yes
	Deceased Child, Male, 1 Years	Father, Male, 19 Years	Internal Injuries	Indicated	
	Deceased Child, Male, 1 Years	Father, Male, 19 Years	Lack of Medical Care	Indicated	
	Deceased Child, Male, 1 Years	Father, Male, 19 Years	Swelling / Dislocations / Sprains	Indicated	
	Deceased Child, Male, 1 Years	Father, Male, 19 Years	Lacerations / Bruises / Welts	Indicated	
	Deceased Child, Male, 1 Years	Father, Male, 19 Years	Excessive Corporal Punishment	Indicated	

Report Summary:
The SCR registered a report concerning injuries the SC sustained while in the care of the father. The father alleged the SC fell; however, the medical staff found the injuries were not consistent with the father's explanation.
The SC was admitted to the hospital and placed on a ventilator. The SC was declared brain dead and died on 6/23/17. The father was arrested and detained at the Riker's Island Correctional Facility awaiting trial. On 6/27/17, the SCR registered a report concerning the SC's death.

Determination: Indicated | **Date of Determination:** 08/18/2017

Basis for Determination:
ACS substantiated the allegations of the report against the father based on the collateral contacts with medical staff, NYPD and the ME. All information gathered noted the father inflicted all the injuries the SC sustained.

OCFS Review Results:
ACS completed a thorough investigation, and made all efforts to contact relevant collaterals concerning the SC. The parents were adolescents and the SC was their only child. However, they resided with their mothers (MGM and PGM) and the siblings.

ACS assessed all the minor children in the home were safe in the care of their parents. There were no allegations pertaining to these children.

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

Issue:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS EVENT List does not reflect a Notice of Indication was issued to the parents.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:
The CONNECTIONS EVENT LIST does not reflect a Notice of Existence was issued for the father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Predetermination/Assessment of Current Safety and Risk
Summary:
ACS selected safety decision 3; however the SC had passed during this investigation.
Legal Reference:
18 NYCRR 432.1(aa)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected a safety decision and safety factors that were not consistent with the case circumstances. At the time the safety assessment was due, the SC had passed and the father was incarcerated.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

The mother was listed as a child in four reports, 3 were merged and indicated. The fourth report listed the mother with no role. The allegations of these reports were: IFCS, PD/AM, LOS and IG.
The father was listed as a child in three reports, two were indicated and one was unfounded. The allegations of these reports were LOS, IFCS, PD/AM and IG.
The review of the parents' history in CONNX does not reflect that they received any type of services.

Known CPS History Outside of NYS

The family had 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