NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SY-14-039 **Prepared by: Syracuse Regional Office**

Issue Date: 9/24/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 11/29/2014
Initial Date OCFS Notified: 12/03/2014

Presenting Information

On 12/3/14, the SCR registered a report with allegations of DOA/Fatality and Inadequate Guardianship. The report stated the SC was found unresponsive at home, while under the sole care of the BM's boyfriend, Parent Substitute. The BM had gone to work for the day leaving the Parent Sub to care for the SC. During this time, the Parent Sub contacted his mother (no relation to SC) saying that the SC was unresponsive. The Parent Sub's mother came to the home and she called 911. EMS and Law Enforcement responded to the scene. The SC was transported to the hospital, where it was determined that the SC had suffered internal injuries, leading to her death. The Parent Sub was arrested for Manslaughter and detained in the local jail. The coroner performed an autopsy following the SC's death.

Executive Summary

The SC was pronounced dead on 11/29/15. The subsequent ME autopsy report showed that the SC had sustained multiple contusions to the trunk and head, with a large liver laceration. The ME stated that the liver injury caused rapid blood loss resulting in a loss of consciousness and death in less than 30 minutes. The Parent Substitute, BM's boyfriend, had sole care of the SC while the BM went to work on the day of 11/29/15. That day, the Parent Sub called his mother stating the SC was lethargic and acting unusual. Emergency Services were called and the SC taken to the hospital. Upon arrival at the hospital, the SC was pronounced dead and examined. The doctor discovered multiple external and internal injuries caused by a blunt force trauma. The Parent Sub was arrested that day for manslaughter, and was believed to have caused the injuries to the SC resulting in her death.

The LDSS reviewed the medical documentation, along with the ME's report following the SC's death. The LDSS conducted interviews with the BM and various family members. The LDSS made collateral contacts with law enforcement, EMS personnel, and the ME. An interview was attempted with the Parent Sub, while he was incarcerated, but the Parent Sub refused to talk with the LDSS CW. Based on all of this information, the LDSS made a finding of abuse in this case, substantiating allegations of DOA/Fatality and Inadequate Guardianship against the Parent Sub.. It was determined that he was solely responsible for the SC at the time of death, and was responsible for causing her fatal injuries. The BM was determined to have no role in this case.

The case was closed following the determination, as there were no surviving siblings in BM's care, Parent Sub remains in jail awaiting the outcome of the criminal charges, and there were no identified service needs requiring further CPS involvement.

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:
NA no further explanation needed.

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:
NA

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: 11/29/2014 **Time of Death:** 10:55 AM

Time of fatal incident, if different than time of death: 10:19 AM

County where fatality incident occurred:	ONONDAGA
Was 911 or local emergency number called?	Yes
Time of Call:	Unknown
Did EMS to respond to the scene?	Yes

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? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not

impaired.

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

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	No Role	Female	25 Year(s)
Deceased Child's Household	Other	Alleged Perpetrator	Male	28 Year(s)

LDSS Response

The LDSS investigation determined the SC to be an otherwise healthy child who died due to abuse by the BM's boyfriend, Parent Substitute. On the day of the SC's death, the BM left her in the care of the Parent Sub. During the course of the day, the Parent Sub contacted his mother, because the SC was acting unusual and lethargic. The Parent Sub's mother came to the home and based on her observation of the SC, called 911. EMS responded and the SC was transported to the hospital and pronounced dead.

The LDSS obtained documentation from the ME and the hospital which detailed the manner of the SC's death. Upon examination at the hospital, it was determined that the SC had suffered a blunt force trauma to both the head and abdomen, causing internal injuries. The most serious of these injuries was a lacerated liver, which based on the LDSS documented collateral contact with the hospital staff, caused internal bleeding and very quickly led to the SC's death.
The LDSS made collateral contact with the hospital staff, and a doctor there stated he thought the SC may have died within 10 minutes of the internal injuries.

The ME ruled this case a homicide. The Parent Sub was arrested and held in jail.

The LDSS CW conducted interviews with the BM and the Parent Sub's mother. The CW also made collateral contacts with the ME, Law Enforcement, family members of both the BM and Parent Sub, hospital staff and EMS staff.
Based on the information gathered during the LDSS investigation, the case was indicated against the Parent Sub for abuse, with the allegations of DOA/Fatality and Inadequate Guardianship. This is based on the LDSS contact with the ME, medical staff and law enforcement. The Parent Sub also refused to talk with CW about this case.

The SC was in the Parent Sub's sole care at the time proceeding her death, and based on the report from the hospital and ME, the information gathered supported that the Parent Sub inflicted the blunt force trauma on the SC, which caused the injuries that ultimately led to the SC's death.

The BM had no role in this case. She was offered grief counseling and financial assistance with funeral arrangements. The BM has no other children in her care, 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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
018481 - Deceased Child, Female, 1 Yrs	018483 - Other - Parent Substitute/Mother's boyfriend, Male, 28 Year(s)	DOA / Fatality	Substantiated
018481 - Deceased Child, Female, 1 Yrs	018483 - Other - Parent Substitute/Mother's boyfriend, Male, 28 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

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:** 1		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
11/29/2014	Parent Substitute	Pending	Parent Substitute remains in jail awaiting trial.
Comments:	Parent Substitute was arrested and charged with manslaughter for his role in the SC's death which is alleged to be that he physically assaulted the SC causing internal injuries to the SC as well as injuries to the SC's face and head. The internal injuries included lacerating the SC's liver, which may have ultimately led to the SC's death. The Parent Sub had sole care of the SC prior to death, and had called his mother stating the SC was acting unusual and lethargic. The Parent Sub's mother observed the child and called 911. The SC was pronounced dead soon after. The police arrested the Parent Sub that day for manslaughter in the 1st degree. He remains in custody awaiting trial.		

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief counseling and financial assistance with funeral arrangements.

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? 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)	Status/Outcome	Compliance Issue(s)
03/20/2012	3725 - Sibling, Female, 9 Years	3721 - Mother, Female, 25 Years	Other	Unfounded	No
	3726 - Sibling, Male, 11 Years	3721 - Mother, Female, 25 Years	Other	Unfounded	
	3727 - Sibling, Male, 7	3721 - Mother, Female, 25	Other	Unfounded	

Years	Years		
3725 - Sibling, Female, 9 Years	3723 - Grandparent, Female, 39 Years	Other	Unfounded
3726 - Sibling, Male, 11 Years	3723 - Grandparent, Female, 39 Years	Other	Unfounded
3727 - Sibling, Male, 7 Years	3723 - Grandparent, Female, 39 Years	Other	Unfounded

Report Summary:
A court ordered investigation (COI) was ordered by the Onondaga County Family Court, following the BM's petition for custody of her three older children (The SC's sibling and two half siblings). Previously, these children were placed with their MGM, following findings of neglect against the BM.

Determination: Unfounded | **Date of Determination:** 04/10/2012

Basis for Determination:
There was no evidence of abuse/neglect in this case for the MGM. The children were determined to be safe and happy at the MGM home, with no issues requiring CPS or Family Court Intervention. The BM's custody petition was denied, and it was determined the children should remain with their MGM.

OCFS Review Results:
LDSS worker adequately determined the outcome of the case. The MGM and BM were interviewed, along with the children in question and collateral contacts.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/22/2013	3728 - Deceased Child, Female, 2 Days	3729 - Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	No
	3728 - Deceased Child, Female, 2 Days	3730 - Father, Male, 27 Years	Inadequate Guardianship	Unfounded	

Report Summary:
BM gave birth to a baby, the SC. Based on the BM's history an SCR report was made

Determination: Unfounded | **Date of Determination:** 06/24/2013

Basis for Determination:
Upon investigation, the LDSS CW determined the report had been made simply based on the BM's history. The LDSS CW determined that the BM had adequate supplies etc for the SC, and the hospital had no other concerns for her ability to care for the SC. No other safety concerns discovered.

OCFS Review Results:
Based on the information in the report the determination to unfound this case was appropriate. This was an open services case at the time of the report. It was investigated and closed, though the case remained open for preventive services.

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

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

From 2006-2008, the BM was named as a confirmed subject on three separate reports for her older three children, two who are the SC' half siblings, and one who is the SC's sibling At the time of the SC's fatality, these three siblings resided in the

legal custody of their MGM. BM was indicated for DV, Lack of Supervision and IG in these reports. The older siblings were placed with their MGM, who later achieved V-Docket custody of the siblings. The BM was listed as a maltreated child in one report. The Parent Sub was indicated and the confirmed subject for the allegation of Lacerations, Bruises and Welts, following him assaulting his girlfriend's 5 month old infant, in 2007.

Known CPS History Outside of NYS

No known history outside of NYS

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

The BM, has three older children. Two of these children are half siblings, and one is a full sibling to the SC. While they were in her custody, the BM with the father of the SC and the siblings received preventive services. The three older children were removed and placed with their MGM, and the BM and the BF continued to receive services. The MGM achieved custody of those children and services ceased. When the SC was born, the BM received preventive services again. This services case was closed, as the BM was taking appropriate care of the SC, maintaining stable housing and there were no further CPS concerns.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There were three separate CPS reports involving each of the SC's older sibling and two older half siblings. Following these, each child was placed with the MGM. According to the history, as each child was born, CPS had to intervene and the each child was placed with the MGM due to unsafe conditions. MGM has permanent custody of these children.

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

Action:	In the determination of this case, the substantiated allegations in regard to the Parent Sub were DOA/Fatality and Inadequate Guardianship. Based on the injuries to the SC and the medical information presented during the LDSS's investigation, it would have been appropriate to add an allegation of Internal Injuries. In this case these allegations were not added. It is recommended that the LDSS form a plan for ongoing examination of the information presented in various cases during the investigation. This plan should include discussion amongst investigators and supervisors around key decisions such as adding allegations to the report, based on the information in the case. Regional Office staff will assist with ongoing technical assistance in this area.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No