Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-22-020

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

Issue Date: Nov 18, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Orange
Gender: Male
Date of Death: 06/02/2022
Initial Date OCFS Notified: 06/02/2022

Presenting Information

Orange County Department of Social Services (OCDSS) received a report from the SCR alleging that on 6/2/22, the 3-year-old subject child died. The mother went to work on the morning of 6/2/22 at 6:00AM. Prior to leaving the residence, the mother transferred the subject child from his toddler bed in her bedroom to another toddler bed in the living room. The child was asleep at the time and the mother's boyfriend was asleep on the couch in the living room. At approximately 7:57AM, the mother's boyfriend called the mother and told her the subject child was having a seizure. The mother instructed the boyfriend to call 911, which he did at that time. EMS arrived and began life-saving efforts and transported the child to the hospital. The subject child was pronounced dead at the hospital at 9:10AM.

Executive Summary

This report concerns the death of the 3-year-old male subject child who died on 6/2/22. At the time of the child's death, he resided with his mother and the mother's boyfriend. The child's father resided outside the home and had inconsistent contact with the subject child. There were no siblings or other children in the home. The family was known to OCDSS as there was an open investigation on an unrelated matter at the time of the subject child's death.

The investigation revealed a neighbor called 911 when they heard the mother's boyfriend was running back and forth through the hallway of the apartment complex yelling for someone to call 911. First responders arrived at the home and found the subject child unresponsive. CPR was performed on scene and the child was transported to the hospital where he was pronounced dead at 9:30AM.

The mother reported she left for work at 6:15AM on 6/2/22. When she left the home, she placed the subject child in his bed in the living room. The mother's boyfriend was asleep on the couch in the same room but woke when the mother was leaving. The mother stated nothing was unusual and her boyfriend asked her to pick up something from the store after work. The mother reported she kept the subject child home from school on that date as he had been sick with symptoms associated with a stomach virus. The mother reported around 7:50AM, her boyfriend called her in hysterics and told her the subject child was unresponsive. The mother returned home and found first responders performing CPR on the child.

OCDSS coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final autopsy report was not yet received at the time this report was written. Law enforcement reported there were concerns noted during the autopsy. The medical examiner found blood in the subject child's abdomen and chest, along with a bruise on the back of the child's head. When the medical examiner attempted to conduct a spinal tap, there was no spinal fluid only blood.

OCDSS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, daycare providers, and relatives. OCDSS provided fatality-related services to the parents upon receipt of the fatality report. Both the SCR and law enforcement investigations remained open pending the results of the final autopsy.

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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The investigation had not yet been determined at the time of this writing. There were no surviving siblings or other children in the household, therefore a safety assessment was not required.

Was the decision to close the case appropriate? N/A
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:
There were no surviving siblings or other children in the household. The investigation had not yet been determined at the time this report was written.

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: 06/02/2022 **Time of Death:** 09:30 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 07:57 AM
Did EMS 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

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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	23 Year(s)
Other Household 1	Father	No Role	Male	35 Year(s)

LDSS Response

On 6/2/22, OCDSS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, OCDSS initiated their investigation within 24 hours and coordinated efforts with their MDT. OCDSS reviewed the family's history, which revealed significant CPS involvement, including an open SCR report unrelated to the fatality.

OCDSS interviewed the mother who reported she left the subject child home with her boyfriend on 6/2/22, and went to work around 6:15AM. She reported discord with her boyfriend while she was at work. The boyfriend text messaged that he was upset about information regarding the mother's ex-boyfriend. The mother then received a phone call from the boyfriend at 7:50AM, stating the subject child was unresponsive. The mother left work and returned home where CPR was being performed on the child by first responders. The mother reported she did not know what happened to the child, though he had been sick to his stomach in the days leading up to his death.

OCDSS observed law enforcement's interview with the mother's boyfriend. The boyfriend was unable to provide an explanation of what happened to the subject child. He reported he did not witness any incident that could have led to the child's death. The boyfriend did not provide any additional information surrounding the morning or days leading up to the death. Due to the nature of the death and the ongoing law enforcement investigation, further interviews with the mother and her boyfriend were not conducted.

OCDSS spoke to the subject child's father who reported having inconsistent contact with the child. The father last saw the child approximately one month prior to the death and the only concern was the child's broken arm. The father stated the information surrounding the fracture was contradictory and he was not sure what happened to cause the child to sustain the injury. The father reported he had no contact with the mother's boyfriend but did not have concerns for the mother caring for the subject child.

An MDT case review was held, and the child's injuries were detailed by the medial examiner investigator. It was revealed the child had head trauma, four lacerations to his liver, posterior rib fractures, and multifocal tissue damage. It was learned the final autopsy had not yet been completed but the case should be investigated as a homicide. The initial impression was that 5/29/22 was the preliminary time frame as to the latest date that the injuries causing the child's death could have been inflicted.

Law enforcement seized the mother and her boyfriend's phones and found nothing of concern on the mother's phone. Law

enforcement performed a "phone dump" of the boyfriend's phone and revealed from 5/30/22, 5/31/22, 6/1/22, and 6/2/22; which revealed searches for: "3 year old head trauma", "getting hit in the head changes shape", "concussion 3 year old", "what happens when shaking a baby too much", "why do men want to hurt babies", "things you shouldn't do with a toddler", "how to deal with a three year old", and "baby breathing heavy after being shook."

Both the SCR and law enforcement investigations remained open at the time of this writing, pending the final autopsy report. At the time of this writing, there had not been any criminal charges in the death. Bereavement services were offered to the parents and grandparents.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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: OCDSS adhered to previously approved protocols for joint investigations by notifying the DA's office of the death and coordinating efforts with law enforcement.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061648 - Deceased Child, Male, 3 Yrs	061649 - Mother, Female, 23 Year(s)	DOA / Fatality	Pending
061648 - Deceased Child, Male, 3 Yrs	061649 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Pending
061648 - Deceased Child, Male, 3 Yrs	061650 - Mother's Partner, Male, 23 Year(s)	DOA / Fatality	Pending
061648 - Deceased Child, Male, 3 Yrs	061650 - Mother's Partner, Male, 23 Year(s)	Inadequate Guardianship	Pending
061648 - Deceased Child, Male, 3 Yrs	061650 - Mother's Partner, Male, 23 Year(s)	Lack of Medical Care	Pending

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:
Relevant collateral sources were interviewed.

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? There was no legal activity.

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	☐	☒	☐	☐	☐	☐	☐
Other, specify: Trauma Services							

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS provided community-based fatality referrals to the mother and father. Information on burial assistance was provided to the father, as he was making funeral arrangements for the child.

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? No
Were there any siblings ever placed outside of the home prior to this child's death? No
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)
04/26/2022	Deceased Child, Male, 3 Years	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 3 Years	Mother's Partner, Male, 23 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 3 Years	Grandparent, Male, 54 Years	Fractures	Unsubstantiated	
	Deceased Child, Male, 3 Years	Grandparent, Male, 54 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Grandparent, Male, 54 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 3 Years	Grandparent, Male, 54 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Child Fatality Report

Report Summary:
OCDSS received a report from the SCR which alleged that on 4/26/22, the subject child sustained a supracondylar fracture of his right distal humerus, swelling to the right elbow, and a bruise on his right cheek, while in the care of the maternal grandfather. No explanation was provided for the injuries.

Report Determination: Indicated	**Date of Determination:** 06/17/2022

Basis for Determination:
OCDSS substantiated the allegations of Lack of Supervision and Inadequate Guardianship against the mother's boyfriend regarding the subject child as the record reflected the boyfriend fell asleep while caring for the subject child and the child sustained a broken arm during the period the boyfriend was asleep. OCDSS unsubstantiated allegations of Inadequate Guardianship, Swelling/Dislocation/Sprains, Fractures, and Lacerations/Bruises/Welts against the grandfather as he was not present at the time the child sustained the injuries and the investigation revealed the mother's boyfriend was with the child.

OCFS Review Results:
OCDSS spoke with relevant collateral sources and completed a thorough investigation into the allegations. The child died during the investigation and a fatality report was registered. OCDSS delivered NOEs late and documented it was due to transferring the case for MDT response.

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

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

OCDSS received a report from the SCR alleging that on 9/22/18, the mother's boyfriend physically assaulted his mother in the presence of his minor sibling, aged 10-years-old. During the altercation, the mother's boyfriend's minor sibling attempted to intervene to help protect their mother. The mother's boyfriend pushed his younger sibling causing the child to fall and hit his head. The child lost consciousness and suffered blurry and double vision as a result. The mother's boyfriend was indicated for Inadequate Guardianship regarding his minor sibling and a safety plan was established.

Known CPS History Outside of NYS

There was no known history outside of New York State.

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