Child Fatality Report

Report Identification Number: AL-19-039

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

Issue Date: May 29, 2020

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	

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Rensselaer
Gender: Male
Date of Death: 12/07/2019
Initial Date OCFS Notified: 12/08/2019

Presenting Information

An SCR report was received with concerns that on 12/7/19, the 3-year-old subject child was in the care of the mother's boyfriend when the boyfriend found the child unresponsive. Emergency services were called and when they arrived at the home, the child was found to have no pulse. The child was transported to the hospital where he was resuscitated, and then transported to another hospital for a higher degree of care. The child died at the hospital due to his injuries, and his cause of death was unknown. The child's mother was at work when the incident occurred.

Executive Summary

This fatality report concerns the death of a 3-year-old male subject child (SC) that occurred on 12/7/19. A report was made to the SCR on 12/8/19 with allegations of Excessive Corporal Punishment, Internal Injuries, Inadequate Guardianship, Lacerations/Bruises/Welts and DOA/Fatality against the mother's boyfriend (PS). There was an additional allegation of Inadequate Guardianship against the child's mother (SM). An autopsy was completed and noted the immediate cause of death was consistent with massive intra-abdominal blood loss from traumatic hepatic laceration, and the manner was homicide.

Rensselaer County Department of Social Services (RCDSS) had been involved with the family since 11/12/19 after an SCR report was received with allegations unrelated to the fatality report. At the time of the child's death, he resided with his mother and 1-year-old sister. The child's biological father (BF) and 4-year-old brother resided at a separate residence; however, the father was actively involved in the child's life. It was discovered on 12/6/19, the mother's boyfriend spent the night at the mother's home so he could watch the child and the 1-year-old sibling while the mother was at work the following day. On 12/7/19, the mother left for work around 9:00 AM, and stayed in communication with her boyfriend via text throughout the day. At approximately 3:50 PM, the boyfriend called the mother and informed her there was something wrong with the child and he could not wake him up. The mother immediately called emergency services and left work. The child was brought via ambulance to a nearby hospital, and then transferred to another due to the severity of his injuries. Although the child was resuscitated, he eventually succumbed to his injuries and was pronounced deceased at 10:35 PM on 12/7/19.

From the time the investigation began to the time of its closure, RCDSS interviewed family members and numerous collateral sources. Due to the criminal investigation, RCDSS was unable to interview the mother's boyfriend regarding the child's death. Law enforcement informed RCDSS the boyfriend admitted to shaking the child, but the detectives would not provide RCDSS with any other details surrounding the incident. The boyfriend was arrested and charged with murder in the 2nd degree, and the criminal proceedings remained ongoing at the time of this writing. There was no criminality found on behalf of the mother. RCDSS found evidence to substantiate all the allegations against the mother's boyfriend, and the investigation was pending closure at the time this report was written.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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:
RCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving siblings.

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: 12/07/2019 **Time of Death:** 10:35 PM

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

County where fatality incident occurred: Rensselaer

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? 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

At time of incident supervisor was: Not 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	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)
Other Household 1	Sibling	No Role	Male	4 Year(s)
Other Household 2	Mother's Partner	Alleged Perpetrator	Male	20 Year(s)

LDSS Response

On 12/8/19, RCDSS received an SCR report regarding the death of SC, which occurred on 12/7/19. RCDSS had been involved with the family since 11/12/19, after a report was received with concerns SM was involved in a physical altercation with BF's significant other while the CHN were present. RCDSS had no concerns surrounding the care of the CHN during that investigation. SM explained she was in a relationship, but refused to give a name, stating he did not reside in her home or care for her CHN. RCDSS did not learn of PS until the department was notified of SC's fatal injuries on 12/7/19. At that time, RCDSS coordinated with LE and learned SC had been found unresponsive at home around 3:55 PM on that date, and was taken by ambulance to a nearby hospital, then transferred to another due to his injuries. RCDSS worked diligently to assess the safety of the SS and found they were safe with BF. Later that night, SC succumbed to his injuries and died. RCDSS learned PS had been caring for SC and the younger SS earlier in the day; however, his whereabouts were unknown after SC was hospitalized.

On 12/8/19, RCDSS interviewed SM at the hospital with LE present. SM explained PS had spent the night on 12/6/19 and planned to watch the CHN for her while she worked the next day. SM stated SC woke up around 8:30AM and told her his stomach hurt. SM said she left the home around 8:45AM to buy Pedialyte for SC, dropped it off to PS around 9:00AM, then went to work. SM stated she texted PS throughout the day, and at 3:53PM, PS called her saying SC would not wake up; SM immediately called 911 and left work. SM said EMS was at the home when she arrived, so she left with the ambulance and had the SS go with a neighbor. SM said PS texted her twice to ask if SC was awake; PS would not say his whereabouts. SM stated 12/7/19 was the only day PS supervised the CHN alone; on two other occasions, his mother was there with him. SM explained she had been dating PS since February 2019 and had never seen any "red flags." She stated he was fine with the CHN but was aware he had a history of DV with the BM of his CH, who resided in NYC. SM stated PS did not discipline her CHN. A safety plan was implemented where the SS would stay with BF until further notice, and

SM would not be allowed around the SS unsupervised.

On 12/8/19, RCDSS met with BF to confirm the safety plan and assess his home; no concerns were noted. BF stated he knew nothing about PS until SM brought him to his home when she tried to fight BF's girlfriend in November 2019. BF denied the CHN ever said anything of concern to him regarding PS and denied seeing marks or bruises on the CHN when they came for visits. BF stated it had been one week since he last saw SC prior to his death.

Throughout the investigation, numerous family members and friends were interviewed surrounding the incident. No one expressed any previous concerns regarding SM, PS or the safety of the CHN. RCDSS spoke with the ME who reported SC's injuries were consistent with being squeezed and "shaken violently." A skeletal survey was completed on the 1yo SS, and no concerns were found. PS was arrested and charged with 2nd degree murder on 12/8/19. LE informed RCDSS that PS admitted to shaking SC because he would not eat his lunch. LE found no criminality on behalf of SM.

Due to the criminal investigation, LE advised RCDSS not to interview PS, and would not provide RCDSS with copies of police statements or names of first responders, stating it would interfere with their case. On 12/13/19, after numerous home visits and interviews with BF and SM, RCDSS agreed the safety plan could be lifted, as SM was found to be credible in her account of events. RCDSS spoke with various collateral sources and offered the family appropriate services in response to SC's death. RCDSS found evidence to substantiate the allegations against PS. The case was indicated and pending closure at the time of this writing.

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 Rensselaer County MDT.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054001 - Deceased Child, Male, 3 Yrs	054002 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
054001 - Deceased Child, Male, 3 Yrs	054006 - Mother's Partner, Male, 20 Year(s)	DOA / Fatality	Substantiated
054001 - Deceased Child, Male, 3 Yrs	054006 - Mother's Partner, Male, 20 Year(s)	Excessive Corporal Punishment	Substantiated
054001 - Deceased Child, Male, 3 Yrs	054006 - Mother's Partner, Male, 20 Year(s)	Inadequate Guardianship	Substantiated
054001 - Deceased Child, Male, 3 Yrs	054006 - Mother's Partner, Male, 20 Year(s)	Internal Injuries	Substantiated

054001 - Deceased Child, Male, 3 Yrs	054006 - Mother's Partner, Male, 20 Year(s)	Lacerations / Bruises / Welts	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:

RCDSS interviewed the family and appropriate collateral sources. Due to the criminal investigation, RCDSS could not interview PS or first responders, per LE's request. Progress notes and other documentation were completed and entered timely.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

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: RCDSS offered the family appropriate services in response to the SC's death.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The SS did not need to be removed as a result of this fatality report.				

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:
12/08/2019	PS	Pending	Unknown

Comments:	On 12/8/19, PS was arrested and charged with 2nd degree murder in regard to the death of SC. PS remained incarcerated and the criminal case was ongoing at the time of this writing.

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:
RCDSS provided the family with appropriate service referrals, including bereavement and mental health counseling, in response to the death of SC.

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? Yes
Explain:
RCDSS provided referrals for grief and bereavement counseling to the parents for the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
RCDSS provided the parents referrals for grief counseling and bereavement services.

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)
11/12/2019	Deceased Child, Male, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother's Partner, Male, 20 Years	Excessive Corporal Punishment	Substantiated	
	Deceased Child, Male, 3 Years	Mother's Partner, Male, 20 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 3 Years	Mother's Partner, Male, 20 Years	Internal Injuries	Substantiated	
	Deceased Child, Male, 3 Years	Mother's Partner, Male, 20 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:
This report was received with concerns SM was upset with BF because he went out with the CHN and his girlfriend to a local restaurant. The report alleged SM physically assaulted BF's girlfriend in the presence of the CHN. Several days later, SM drove to BF's home with an acquaintance and became aggressive toward BF and his girlfriend again in the presence of the CHN. There were no injuries. A SUB report was received on 12/7/19 after SC was found unresponsive while in the care of PS.

Report Determination: Indicated | **Date of Determination:** 05/05/2020

Basis for Determination:
RCDSS completed a thorough investigation into the allegations that included interviews with family members and collateral sources. SM reported she drove to BF's home upset he had the CHN around his girlfriend, but denied she had anyone with her when this occurred or that she became aggressive. RCDSS assessed the safety of the CHN and found no concerns at that time. RCDSS fully explored the allegations in the SUB report and found PS was responsible for fatally injuring SC. RCDSS was unaware SM was dating PS and around her CHN until the SUB report was received. SC died while this investigation was ongoing.

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

In 2015, PS was indicated for IG after an altercation between himself and the mother of his child occurred in the presence of the child. PS was incarcerated and in 2016, his child was removed from the care of her mother and placed in foster care. PS had inconsistent contact with his child since her birth, and did not comply with Family Court orders to receive mental health and substance abuse treatment, complete parenting classes, and attend supervised visitation with his child regularly. At the time of this writing, the child resided in the care and custody of a relative in New York City.

Known CPS History Outside of NYS

There was no known CPS 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