NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-102 **Prepared by: New York City Regional Office**

Issue Date: 4/21/2016

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	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-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 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/10/2015
Initial Date OCFS Notified: 12/21/2015

Presenting Information

On 12/21/15, the SCR registered a report alleging that the SC was in the care of his parents on 12/10/15 when he was strangled by his father. The report alleged that the SC sustained fractures to his skull, which subsequently led to his death. The mother was in the apartment at the time of the incident and found the SC unresponsive, she threw water on the SC, but he did not respond. The report noted that niether parent sought medical care for the SC.

Executive Summary

The SC was one month old when he died on 12/10/15. The Dutchess County's ME completed an autopsy, but has not issued the report.

On 12/21/15, the SCR registered a report with allegations of DOA/Fatality, Choking/Twisting/Shaking, Fractures, Lack of Medical Care, and Inadequate Guardianship of the SC by the parents. The mother had no other children and the father had two adult children with whom he had no contact.

According to ACS' investigation, on the morning of 12/10/15, the SC woke up crying and the father offered to attend to the SC. The mother indicated that she heard the father using foul language and screaming at the SC telling him to "shut up." The mother also indicated that she heard three loud "bangs" and then the father returned to the room without the SC. The father told the mother that there was something wrong with the SC and when she went to check the SC, he was unresponsive. The mother said she threw water on the SC, but he did not repond. The mother said she suggested that they call 911, but the father refused and threatened to bury her alongside the SC if she did. The mother later denied being threatened by the father. The father then placed the SC in a duffel bag and drove with the mother and the SC's body to Brewster, New York where they left the SC's body in the woods.

The parents returned to the Bronx and remained in the apartment for days until 12/18/15 when the mother convinced the father that she had to go to her job to pick up her paycheck. While she was out of the home, the mother attempted to commit suicide and was taken to the hospital where she disclosed the incident. The mother led the police to the SC's body and as a result, the father was arrested on 12/19/15. On the same day, the mother was admitted to New York Presbyterian Hospital in Westchester County.

ACS was assigned this investigation after the NYPD had conducted their interviews with the parents. Based on the statement provided to the NYPD by the father, he was arrested and charged with Murder in the 2nd degree and Manslaughter. The father attempted to commit suicide when he was arrested; therefore, he was taken to Bellvue Hospital for observation. He was subsequently released to Riker's Island Correctional Facility where he remains.

Initially, the mother was not arrested, but after the case was presented to a grand jury, she was indicted and charged with Manslaughter. The mother was arrested on 1/26/16 upon release from the hospital. However, her family paid her bail and she was released pending her next court date.

ACS' Family Court Legal Services (FCLS) reached out to the parents' attorneys to interview the parents. However,

due to the criminal charges the parents faced, neither attorney allowed ACS to contact their client.

The circumstances of this case did not allow for ACS to establish a definitive timeline of the events; therefore, the Specialist only documented the information as reported by collaterals. The Bronx Field Office conducted a comprehensive investigation in spite of all the barriers they faced. ACS did an excellent job with interviewing those key collaterals that were made available, in order to obtain crucial information concerning the death of the SC.

On 2/19/16, ACS indicated the report based on the information obtained from the collaterals which reflected that the father made statements regarding his direct role in the child's death.

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

Date of Death: 12/10/2015 **Time of Death:** Unknown

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

County where fatality incident occurred: BRONX
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	51 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)

LDSS Response

ACS had no access to the parents as the father was in police custody at Bellevue Hospital and the mother was admitted to New York Presbyterian Hospital when the report was registered with the SCR. ACS focused on obtaining information surrounding the SC's death by keeping in contact with the NYPD and the Bronx ADA.

ACS' investigation revealed that the BF told the NYPD that he killed the SC, but there were no details of his statements. However, ACS learned from the NYPD and the ADA that according to the BM, on 12/10/15, the SC started to cry and the father got up to attend to him. The BM said that the BF told her something was "wrong" with the SC. The BM said she heard three loud "bangs" and went into the bedroom where she found the SC was faintly breathing and one to two minutes later he expired. The BM said when she told the BF that they should call 911, he said they would get in "trouble." According to the BM, prior to this incident, she had seen the BF grab the SC by the neck while using foul language, but never reported the incidents. After the parents realized the SC was dead, the BF placed him in a duffel bag and left him for two days.

On 12/12/15, the parents drove to Brewster, NY and disposed of the body in a wooden area. The parents stayed in a motel for a couple of days and then returned to the Bronx. Days later, the BM told the BF that she had to pick up her paycheck, and she was able to get out of the apartment. According to the NYPD, the BM went to Manhattan and overdosed on pills. She was taken to a psychiatric facility where she told the hospital staff about the incident. The NYPD did not have details of the BM's suicide attempt and had no information as to who called 911. On 12/19/15, the BM led the NYPD to the location of the SC's body where he was found in the woods dressed in a green flannel shirt, faced down and without any pants.

The NYPD noted that they viewed the home and found the parents had provisions for the SC. There was clothing around the home and a lot of empty "crack bags." The BM disclosed to the NYPD that both she and the BF smoked "crack/cocaine." The NYPD indicated that the mother did not disclose that the BF held her against her will or that there was any domestic violence (DV). However, she stated that the BF told her that if she became a "liability" he would bury her by the SC. According to the ADA, the BM admitted to using cocaine once when she was pregnant, the night prior to the SC's death and on the night before attempting suicide.

On 12/23/15, the case was heard by a grand jury and the BM was indicted for manslaughter. She was arrested upon her release from the hospital and transported to Riker's Island; however, she was subsequently released as her brother paid her bail.

ACS learned from the building superintendent and neighbors that the family had resided at the case address less than a year and no one knew them well. There were no concerns of DV; however, neighbors had complained of the smell of marijuana coming from the parents' one-bedroon apartment. The superintendent noted the BF would sometimes complain about the SC not letting him sleep. The superintendent allowed ACS access to the apartment and ACS observed the SC had adequate provsions. There was evidence of crack cocaine and marijuana use. ACS viewed a tape of the building's video camera in which the BF was seen driving away with a duffle bag where it was presumed the SC's body was transported.

ACS interviewed the MU who indicated he had no knowledge of the parents' drug use or information of DV in their relationship. ACS contacted the BM's employer who noted that she was on maternity leave from 10/19/15 through 12/8/15; she called in sick on 12/10/15 and 12/11/15. The mother told her employer that the SC died of SIDS. On 12/15/15, the mother picked up her paycheck and reported she was not certain about the funeral arrangements.

On 2/19/16, ACS indicated the report based on the information gathered.

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
027001 - Deceased Child, Male, 1 Mons	027002 - Mother, Female, 31 Year(s)	DOA / Fatality	Substantiated
027001 - Deceased Child, Male, 1 Mons	027002 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
027001 - Deceased Child, Male, 1 Mons	027002 - Mother, Female, 31 Year(s)	Lack of Medical Care	Substantiated
027001 - Deceased Child, Male, 1 Mons	027003 - Father, Male, 51 Year(s)	Lack of Medical Care	Substantiated
027001 - Deceased Child, Male, 1 Mons	027003 - Father, Male, 51 Year(s)	Choking / Twisting / Shaking	Substantiated
027001 - Deceased Child, Male, 1 Mons	027003 - Father, Male, 51 Year(s)	Fractures	Substantiated
027001 - Deceased Child, Male, 1 Mons	027003 - Father, Male, 51 Year(s)	DOA / Fatality	Substantiated
027001 - Deceased Child, Male, 1 Mons	027003 - Father, Male, 51 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Other	☐	☐	☐	☒
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:

The SC was not taken to an ER. The parents attorneys did not allow ACS to interview them due to the criminal charges. ACS was unable to obtain information about the SC's pediatrician due to the HIPAA laws.

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Father	Pending	Unknown
Comments:	UNKNOWN		

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

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

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The family received support from Victim's Services for the SC's funeral.

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 are no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
N/A

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? No

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:

☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history within three years prior to the fatality.

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

The family had no CPS history.

Known CPS History Outside of NYS

The family had no known CPS history outside 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

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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 is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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:	OCFS is recommending that ACS Supervisory Team review with the Specialists the CONNECTIONS' Step-by-Step Guide: Training for CPS Workers (rev 3/1/07) page 204, which addresses Safety Assessments, and to review the Safety Assessments submitted for this report. Staff must be reminded that when there are no surviving siblings and/or minor children in the home, the Specialist must select "no surviving siblings" in the Investigation Conclusion window of the CONNECTIONS database at the inception of the investigation to prevent the CONNECTIONS system from generating the Safety Assessments and Risk Assessment Profile.

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