Child Fatality Report

Report Identification Number: NY-16-085

Prepared by: New York City Regional Office

Issue Date: Mar 21, 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	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 08/15/2016
Initial Date OCFS Notified: 08/16/2016

Presenting Information

On 8/16/16, the SCR registered a report alleging that on 8/15/16, the 1-year-old SC was picked up from the day care by her babysitter (BS). After the SC arrived at the BS's home, the SC was placed to sleep. The report alleged that when the SC woke up, he was crying, vomiting and acting strangely. The report stated the BS called 911 and EMS responded to the BS's home and found the SC unresponsive. EMS attempted to revive the SC, but was unsuccessful and he was pronounced dead at the hospital.

The report noted the SC had no injuries or marks on his body and was an otherwise healthy child. The cause of death was unknown. There were no other children in the SC's home.

Executive Summary

The SC was one-year-old at the time of his death. The ME's preliminary findings of the cause and manner of death were undetermined.

On 8/16/16, the SCR registered two reports with allegations of DOA/Fatality and Inadequate Guardianship of the SC by the mother and the babysitter. This was the mother's only child and she reported the father was not involved in the SC's life.

The SC resided with his mother, MGM and two minor maternal uncles (MUs). ACS assessed there were no concerns about the care the MUs were receiving from the MGM.

At the time of the SC's death, he was in the care of his babysitter who had known the family for about six weeks.

According to the babysitter, she picked up the SC from the day care at approximately 4:19 P.M. and brought him to her home. The babysitter said she attempted to feed the SC food she had blended for him, but he refused to eat so she gave him a bottle of milk and placed him to sleep on the sofa. The babysitter said she had a fan in the room, but did not place it over the SC because about a week prior to the fatality the SC was "congested."

The babysitter said the SC woke up at about 7:00 P.M and he refused to drink another bottle of milk. The babysitter said the SC was crying and vomiting. The babysitter also noted the SC was having difficulty breathing. The babysitter called her adult daughter who advised her to call EMS. The babysitter said she called her husband who followed through with calling 911. ACS' documentation, noted the husband called 911 at 7:15 P.M. When EMS arrived the SC was transported to Kings County Hospital (KCH). The SC arrived at the hospital at 7:21 P.M. and pronounced dead at 7:57 P.M. The babysitter did not accompany the SC in the ambulance because she had to stay home with her 4 month old infant. However, as the ambulance was departing the babysitter's adult daughter and husband were just arriving to the home and proceeded to the hospital. ACS interviewed the adult daughter and husband, and confirmed the babysitter's account.

ACS observed the babysitter's infant and assessed her to be safe in the care of her mother, the babysitter.

ACS also interviewed the day care provider (DCP) and the mother who indicated the SC was well on the morning of 8/15/16 and during the time he was with the DCP. ACS confirmed this was a licensed DCP and there were no licensing concerns.

Based on the NYPD's investigation and the medical staff from KCH's examination of the SC, there were no concerns or suspicion of abuse or maltreatment concerning the care of the SC.

On 10/28/16, ACS unsubstantiated the allegation of DOA/Fatality against the mother and the babysitter based on the information obtained from the NYPD who found no evidence to make an arrest and the fact that the mother was not caring for the SC at the time of the incident. The allegation of Inadequate Guardianship was unsubstantiated against the babysitter because she acted according in attempting to seek medical attention for the SC. ACS substantiated the allegations of Lack of Medical Care and Inadequate Guardianship against the mother because the investigation revealed the SC was ill prior to the fatality and the mother was unable to provide information about the SC's pediatrician or the last time the SC was taken to see his doctor.

ACS determination to substantiate the LMC and IG were not supported by case documentation. There is nothing documented to indicate the SC was medically neglected by the BM or his basic needs were not being met. ACS' documentation reflected the SC had no medical issues or was well cared for prior to the 8/16/16 report.

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?** No

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	This 7-Day safety assessment was not completed timely.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	This safety assessment was not completed timely.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24 Hour Child Fatality Report was not completed timely.
Legal Reference:	CPS Program Manual, VIII, B.1, page 2
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to Provide Notice of Indication
Summary:	The CONNECTIONS event list does not reflect the NOI was issued to the BM.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	ACS' determination to substantiate the allegations of LMC and IG against the BM was not supported by case documentation. There is no documentation the SC was negatively impacted medically, or in any way, by the quality of care provided by the BM.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/15/2016 **Time of Death:** 07:57 PM

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 07:15 PM
Did EMS to respond to the scene? Yes
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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 15 Minutes
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	Aunt/Uncle	No Role	Male	9 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	11 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Other Household 1	Other Adult	No Role	Male	39 Year(s)
Other Household 1	Other Adult	No Role	Female	23 Year(s)
Other Household 1	Other Adult	Alleged Perpetrator	Female	41 Year(s)
Other Household 1	Other Child	No Role	Female	4 Month(s)

LDSS Response

Following the fatality reports, ACS conducted the investigations simultaneously.

The NYPD deemed the babysitter's (BS's) home to be a crime scene. ACS used an interpreter service to interview the BS at the home she was staying following the fatality.

The BS indicated she had only known the family for six weeks when she began caring for the SC. The mother was referred to the BS by the BS's daughter's friend. ACS later visited the home and documented there were no safety hazards.

The BS indicated she picked up the SC from the DCP at 4:19 P.M. on 8/15/16. When the BS arrived at her home, she gave the SC a bottle of milk and the child fell asleep. The BS indicated the SC awoke approximately 7:00 P.M. and attempted to feed the SC, who began coughing and vomiting. The BS noted the SC was also having difficulty breathing so she called her adult daughter who instructed her to call 911. The BS stated she was unable to accompany the SC in the ambulance, but her daughter followed the ambulance to the hospital and later called her to report the SC's death.

The BS's daughter told ACS she arrived at the home as the ambulance was pulling off with the SC. The daughter noted she and her stepfather went to the hospital and learned of the SC's death.

The mother was interviewed at the borough office on 8/17/16. The mother said she dropped off the SC at the day care between 9:00 A.M and 10:00 A.M. and then left for work. The mother stated the SC would usually be picked up at the day care by the BS at 5:00 P.M. and would retrieved the SC from the BS after work. The mother said she sometimes worked as late as 8:00 P.M. The mother indicated the SC was fine on 8/15/16 when she dropped him off at the day care. The mother said she was notified the SC was at the hospital by a relative of the BS and she arrived at the hospital at 7:50 P.M. where she learned the SC had expired.

The mother said that on 8/13/16 she dropped off the SC at the BS's home at approximately 10:00 P.M. According to the mother, the BS would also care for the SC whenever she (mother) wanted to go out. The mother stated she went to the BS's home on 8/14/16, at about 12:00 P.M., to pick up the SC. The mother said the BS offered to keep the SC longer because she (mother) was tired. The mother said she returned to the BS's home to pick up the SC at about 5:00 P.M. and he seemed fine. However, the SC was warm to the touch so she gave the SC over the counter medication as per the instruction on the box. The BS corroborated the mother's account. However; she said she told the mother on 8/14/16 to take the SC to the doctor.

The mother said that later in the day, she took the SC's temperature and it was 97 degrees Fahrenheit.

The DCP indicated that on 8/15/16, the SC's behavior was normal, the SC was playful and happy. The DCP also stated the SC had not been ill recently and there was no problem with his feeding nor were there any reported allergies.

ACS contacted family members who did not have any concerns of abuse on the part of the mother. However, a maternal aunt (MA) indicated the SC was "sickly" and the mother did not always take him to the doctor. The MA said it might have been due to the mother's age or inexperience; therefore, she (MA) took on the responsibility of taking the SC to the doctor. The MA also noted the mother had difficulty in getting a consistent doctor for the SC because she had problems with the medical insurance. According to the MA, the insurance was changed by public assistance without notice. ACS confirmed the SC's immunizations were current.

Neither the NYPD nor the medical staff who attended to the SC had any concerns of abuse.

On 10/28/16, ACS substantiated the allegations LMC and IG of the SC by the BM. However, based on ACS documentation, there does not appear there was any credible evidence to support these allegations. There is no documentation the SC was medically neglected or that his basic needs were not being met.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Unknown
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
030701 - Deceased Child, Male, 1 Yrs	034741 - Other Adult - Babysitter, Female, 41 Year(s)	DOA / Fatality	Unsubstantiated
030701 - Deceased Child, Male, 1 Yrs	034741 - Other Adult - Babysitter, Female, 41 Year(s)	Inadequate Guardianship	Unsubstantiated
030701 - Deceased Child, Male, 1 Yrs	030702 - Mother, Female, 20 Year(s)	Lack of Medical Care	Substantiated
030701 - Deceased Child, Male, 1 Yrs	030702 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
030701 - Deceased Child, Male, 1 Yrs	030702 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated

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?	☐	☒	☐	☐
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?	☒	☐	☐	☐

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 safety 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	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: N/A				

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	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: 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 immediate services needed.

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

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

CPS - Investigative History Three Years Prior to the Fatality

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

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

Neither the mother nor the babysitter had a CPS history.

Known CPS History Outside of NYS

Neither the mother nor the babysitter had a known history outside of NYS.

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.

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

Additional Local District Comments

N/A

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