Child Fatality Report

Report Identification Number: NY-17-086

Prepared by: New York City Regional Office

Issue Date: Feb 21, 2018

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		

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 09/06/2017
Initial Date OCFS Notified: 09/06/2017

Presenting Information

The 9/6/17 SCR report alleged the SC was found deceased in the home. The SC was an otherwise healthy child with no pre-existing conditions that would have contributed to his death. The SC had no noticeable injuries and the cause of death at the time was cardiac respiratory arrest. The SC was declared dead at 2:38 PM on 9/6/17. The one-year-old male SS had an unknown role. The female nanny was caring for the SC and SS at the time of the SC's death. The nanny was named the alleged subject of the report. The parents were not home at the time of the SC's death and had unknown roles.

Executive Summary

This 3-month-old male child died on 9/6/17. On 2/13/18, NYCRO received the final autopsy report. The ME listed the SC's cause of death as congenital coarctation of the aorta and the manner of death as natural.

The allegations of the 9/6/17 report were DOA/Fatality and IG of the SC by the nanny.

ACS investigated the 9/6/17 report and found that the nanny was a caretaker for the SC and SS. The nanny arrived at the home around 6:30 AM on 9/6/17. Shortly thereafter, the parents left the SC and SS in the nanny's care and went out of the home. The nanny said she observed that the SC was unusually fussy. She fed the SC 4 ounces of milk and around 8:00 AM she took the SC and SS for a walk outside of the home. At approximately 10:30 AM she returned to the home with the children and around 10:45 AM she placed the SC in the bassinet on his back for a nap. At around 2:00 PM, she found him unresponsive with his head turned to the left side. The nanny called the parents and she was instructed to call 911. The nanny received CPR instructions. EMS arrived at the home and performed CPR on the SC. Shortly thereafter, the BM arrived to the home. EMS transported the SC to the hospital while the BM was escorted by LE. The nanny remained in the home with the SS. At approximately 2:25 PM the SC arrived in the ER where medical staff continued emergency treatment. The SC was pronounced dead at 2:38 PM.

The family resided in a three-bedroom apartment. ACS observed a sufficient supply of provisions for the SC and SS in the home. The parents had a portable bassinet that contained a bumper for the SC. The 22-month-old male SS had adequate sleeping arrangements. The home contained a functional smoke/carbon monoxide detector and window guards. There were no safety hazards observed in the home.

During the investigation, ACS gathered pertinent information about the circumstances surrounding the SC's death by visits to the family's home, statements from the parent's, nanny, LE, first responders, apartment building staff and medical staff. ACS also interviewed significant collaterals who had no concerns regarding the care the parents provided the children. ACS noted the nanny's timeline of events had significant discrepancies related to the last time she fed the SC and observed him alive. The parents relieved the nanny of her child care responsibilities of the SS. The parents provided the SS with ongoing care and supervision. The SS appeared healthy and well cared for and no safety concerns were identified.

On 11/3/17, ACS opened a services case and offered the parents PPRS. On 12/4/17, the parents ceased communication with ACS and on 12/14/17, ACS closed the services case.

On 11/28/17, ACS added the allegation of LS of the SC by the nanny to the 9/6/17 report. ACS substantiated the

allegations of IG and LS on the basis that the nanny failed to monitor the SC within realistic timeframes and did not respond accordingly to the incident when the SC was found unresponsive. ACS unsubstantiated the DOA/Fatality allegation of the SC by the nanny on the basis that no credible evidence was found to support the allegation. ACS added that the ME's report was pending.

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

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:	The SCR report was received on 9/6/17. The 7-Day Safety Assessment was inadequate as it did not accurately reflect the safety of the SS at that time and it was a duplicate of the 24-Hour Safety Assessment.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took to address the citations 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.

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-Hour Safety Assessment was inadequate as it did not accurately reflect the safety of the SS at the time.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took to address the citations 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.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The SCR report was received on 9/6/17. The 30-Day Fatality Report and the corresponding Safety Assessment were approved on 10/26/17 and 10/23/17 respectively; not within the required timeframe.
Legal Reference:	CPS Program Manual, VIII, B.2, p.4
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency will take or took to address the citations 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: 09/06/2017 **Time of Death:** 02:38 PM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 02:02 PM
Did EMS 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? 3 Hours
Is the caretaker listed in the Household Composition? No
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 Month(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Deceased Child's Household	Mother	No Role	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Other Adult - Nanny	Alleged Perpetrator	Female	53 Year(s)

LDSS Response

According to LE, there were discrepancies in the statements the nanny provided. The ME stated that there were no suspicious injuries or trauma observed to the SC's body. There were no criminal charges pursued against the nanny.

On 9/6/17, hospital staff stated the SC was dead for a long period of time as he arrived to the hospital cold and stiff.

On 9/6/17, the parents stated they were not home at the time of the incident. The parents denied DV, MH and substance abuse. The SC had no preexisting medical conditions. The nanny had been working for the parents as the children's caretaker since 2016. The parents said the bassinet was kept in their bedroom. They had no concern with the care the nanny provided the children prior to the SC's death. The BF reported that the nanny called about the SC's condition. He instructed the nanny to call 911. The BM received a text message from the nanny.

On 9/6/17, ACS assessed the home and SS for safety. The SS was observed to be well cared for, exhibited age appropriate behavior and had no visible marks or bruises. The home was observed to have sufficient provisions for the SS. There were no safety concerns observed at the time of the home visit.

According to the nanny, the SC was healthy. The SC was on a strict schedule where he was fed 4 ounces of milk every two hours and usually woke up two hours later for a feeding. The nanny confirmed she fed the SC around 8:30 AM and returned to the home from the laundry with the children at 10:30 AM. She said the SC was alert when she placed him on his back in the bassinet around 10:45 AM. She did not observe the SC again until about 2:00 PM. She observed the SC's head was turned to the left side and was unresponsive when she touched his feet. The nanny said she did not observe discoloration, marks or bruises on the SC. The nanny sent a text to the parents, she contacted a fellow nanny and building staff for assistance with contacting 911. The nanny called 911 and attempted CPR until EMS arrived.

On 9/7/17, ME stated the SC had no injuries. The cause of the SC's death was pending further studies.

ACS found that the Dr. last saw SC on 8/25/17. The Dr. noted that SC had a pre-existing medical condition and was prescribed treatment. The SC and SS's immunizations were up to date, they met developmental milestones and there were no medical concerns.

On 10/3/17, ACS contacted the apartment building's staff who had been on duty at the time of the incident. ACS learned that at approximately 2:00 PM another nanny in the building used the lobby phone to call 911 regarding the SC. The staff went to the home and heard the nanny receiving CPR instructions from 911; however, the nanny stated she did not know

how to perform CPR. The staff said the SC was observed in the side laying position and his face was pressed against the bassinet. The SC appeared stiff and his upper body and legs were a bluish-purple color. EMS arrived and attempted CPR. EMS escorted the SC from the home. The staff did not observe the nanny perform CPR or leave the building with the children.

On 11/3/17, ACS opened a services case and offered the family bereavement and therapeutic services.

On 11/15/17, first responders noted the 911 call was received at 2:02 PM. EMS arrived at the home at 2:09 PM. The SC was observed face down in the crib. EMS observed the SC was cold and hard with blood pooled to the front side of his body.

On 11/17/17, ACS held a case conference at the ACS office. The parents participated via telephone. The parents decided to obtain services privately.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
040721 - Deceased Child, Male, 3 Mons	043826 - Other Adult - Nanny, Female, 53 Year(s)	Lack of Supervision	Substantiated
040721 - Deceased Child, Male, 3 Mons	043826 - Other Adult - Nanny, Female, 53 Year(s)	Inadequate Guardianship	Substantiated
040721 - Deceased Child, Male, 3 Mons	043826 - Other Adult - Nanny, Female, 53 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?	☒	☐	☐	☐
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:

There were progress notes entered untimely.

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The documentation did not reflect ACS offered the parents funeral/burial arrangement assistance. No EI intervention referral was submitted for the SS.

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? No
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 in NYS within three years prior to the fatality.

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

The family nor the nanny had CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS for neither the parents or nanny.

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