Child Fatality Report

Report Identification Number: NY-18-025

Prepared by: New York City Regional Office

Issue Date: Sep 05, 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: 03/15/2018
Initial Date OCFS Notified: 03/15/2018

Presenting Information

The 3/15/18 SCR report alleged that on 3/15/18, the SC passed away while in the care of the babysitter. The SC was found unresponsive and bluish in color in a bassinet at 4:10 PM. It was unknown if the SC had any pre-existing conditions which contributed to his death. Since the babysitter was acting as the sole caregiver at the time of the SC's death, she was considered the alleged subject.

Executive Summary

The 3-month-old male child (SC) died on 3/15/18. An autopsy was not conducted; however, the ME performed an external examination of the SC's body. OCFS obtained a copy of the Report of External Examination in which the ME listed the cause of death as Undetermined and manner of death as Undetermined.

The allegations of the 3/15/18 report were DOA/Fatality, IG, and LS of the of the SC by the babysitter.

ACS found that on 3/15/18, the BM arrived at the home of the babysitter with the SC after 10:00 AM. The BM then left for work. The BM returned to the babysitter's home at about 4:07 PM, and went to the bassinet in which the babysitter had placed the SC to sleep. When the BM lifted the SC, he was limp, his face was blue, and he was unresponsive. The SC had been covered with a blanket and he wore a white onesie. The BM informed the babysitter that the SC was not breathing and the babysitter called 911. The babysitter began CPR until EMS arrived.

The babysitter informed ACS that the SC was brought to her home in the morning. Between the time the SC was dropped off and 12:30 PM there were no concerns. The babysitter fed the SC a bottle of milk and then she burped him. At 2:00 PM, she placed him on his stomach in the bassinet to sleep. The babysitter described the bassinet as a stroller that had the bassinet attached. The babysitter said the BM had secured the bassinet. The babysitter said the SC's head was turned to the side and she placed a blanket up to the SC's shoulders. At about 3:20 PM, she checked the SC and observed he was breathing. At about 4:07 PM, the BM returned and was with the babysitter's 15-yo female CH. The 15-yo CH went to the babysitter and told her the SC was not breathing. The babysitter then called EMS and provided CPR while holding the SC.

The babysitter's 15-yo CH was in the home and observed the SC had been playful and was fed milk from a bottle. This CH changed the SC's diaper prior to the time the SC was placed to sleep. The babysitter had eight children and a niece who resided in her home.

Per the ACS case record, at the time of the incident, the BM called the BF, informed him that the SC was not breathing and asked him to visit the babysitter's home. The BF found that the BM and SC were on the way to the hospital. The BF went to the hospital where the attending physician advised the family of the SC's death. The SC had no surviving siblings and the BM and BF did not have surviving children in their household.

On 3/16/18, LE said the babysitter would not be arrested. No arrest could be made as the family declined an autopsy, the SC was buried and there was no evidence of criminality.

On 3/28/18, during a conference the father of the babysitter's children said that his 15-yo CH was in distress caused by the fatality. He said he ensured she met with a family friend to discuss her thoughts and feelings. This father said the 15-yo niece and 15-yo CH received therapeutic services, he accepted PPRS, but preferred meeting with the family therapist.

ACS discussed safe sleep practices and provided written information to the family. Subsequently, the babysitter's family declined ACS offer for services.

On 4/13/18, ACS offered the BM bereavement counseling. The BM declined the services for the family. The BM said she did not direct the babysitter to place the SC on his stomach and did not provide her with specific instructions. The BM said she placed the SC on his stomach only when he had difficulty falling asleep.

On 6/12/18, ACS Unsub the allegations of DOA/Fatality, IG, and LS due to a lack of credible evidence. The cause of death by the ME's office was undetermined. The ME found there were no observable physical injuries or signs of trauma, and the death was not considered suspicious. An autopsy was not performed due to religious objections.

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:
NA

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS documentation reflected there were notes that were not entered contemporaneously, including events that occurred on 3/28/18 and 4/23/18 but was not entered until 5/16/18 and 6/11/18, respectively.

Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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:	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 Summary Report document was not completed within 24 hours of receipt of the 3/15/18 SCR report as it was not completed until 3/19/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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 30-Day Child Fatality Summary Report document was not completed within 30 days of receipt of the 3/15/18 SCR report as it was not completed until 4/17/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take 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: 03/15/2018 **Time of Death:** 04:50 PM

Time of fatal incident, if different than time of death: 04:10 PM

County where fatality incident occurred: Kings
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? 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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	20 Year(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)
Other Household 1	Father	No Role	Male	38 Year(s)
Other Household 1	Other - Babysitter	Alleged Perpetrator	Female	38 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Male	6 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Female	12 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Female	17 Year(s)
Other Household 1	Other Child - Babysitter's niece	No Role	Female	15 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Female	10 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Male	3 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Male	14 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Female	15 Year(s)
Other Household 1	Other Child - Babysitter's child	No Role	Male	7 Year(s)

LDSS Response

On 3/16/18, ACS interviewed an attending physician who said the SC was found limp and bluish in color.

On 3/16/18, ACS visited the home of the babysitter. The babysitter reported that at 2:00 PM, she observed the SC seemed tired so she placed the SC on his stomach in the bassinet to sleep. The SC's head was turned to the side and she placed a blanket up to the SC's shoulders. While he slept, she did household chores. At about 3:20 PM, she observed the SC was breathing. At about 4:07 PM, the BM arrived at her home and was with the babysitter's 15-yo CH. The 15-yo CH went to the babysitter and told her the SC was not breathing. The babysitter then called EMS and provided CPR.

ACS learned that the babysitter's 15-yo CH had observed the SC prior to the time he was placed to sleep. This child observed the SC had been alert and playful and was fed from a bottle. She changed the SC's diaper before the SC went to sleep. She provided details related to the time the infant was found unresponsive and her account was similar to the explanation that was previously documented in ACS case record. ACS staff observed eight of the nine CHN, who were listed in the household composition, were asleep in their rooms. ACS found these CHN did not have visible marks or bruises.

On 3/16/18, ACS interviewed the SC's BM and BF. The BM said she arrived at the home of the babysitter at about 4:10 PM, and walked to the stroller/bassinet in which the SC was found. When she lifted the SC, he was limp, face was blue,

and unresponsive. She told the babysitter that the SC was not breathing. The BM said the SC was seen by the Dr. for a medical issue during the week prior to 3/15/18. The SC was not prescribed medication. The BF said on 3/15/18, he became aware of the incident when he received a call from the BM who said the SC was not breathing. The BM and BF reported they practiced safe sleep and the SC slept in a crib.

On 3/16/18, the ME reported there were no observable physical injuries or signs of trauma, and the death was not considered suspicious. The family objected to an autopsy. The ME noted the concern that the SC was at the babysitter's home and was placed face down to sleep. The ME said in such cases the death certificate would reflect "undetermined" as the cause of death. ACS asked the ME whether the sleep position may have contributed to cause the SC's death. The ME said that it may have, but without an autopsy the cause of death could not be definitively determined.

On 3/19/18, ACS interviewed the babysitter who explained that she received safety training that did not include CPR training. She said she placed the SC in the "stroller" so he would be able to see everyone and play with the 15-yo female CH who was in the home. At about 11:30 AM, he seemed tired so she took him out of the "carriage" and placed him in the bassinet. The SC slept until 12:30 PM, and when he awoke she fed him and the 15-yo changed his diaper. She placed him on his stomach to sleep. This was the first time she placed the SC on his stomach to sleep, as she had been instructed to do so by the BM if she wanted the SC to sleep well. She said she checked him once at 3:20 PM by placing her hand on his blanket with which he was covered, and saw half of his face. The SC was lying face down with the blanket partially covering him. The BM arrived at her home at about 4:10 PM and she told the BM she did not feed the SC the second bottle as he was asleep and she did not want to wake him. The BM walked over to the SC, picked him up and told her the SC was not breathing.

The father of the babysitter's CHN said the babysitter contacted him by telephone regarding the incident. The babysitter told this him to return home immediately. ACS interviewed the babysitter's eight CHN and niece who were included in the household composition.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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 investigations.

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
047086 - Deceased Child, Male, 3 Mons	047089 - Other - Babysitter, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
047086 - Deceased Child, Male, 3 Mons	047089 - Other - Babysitter, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated

047086 - Deceased Child, Male, 3 Mons	047089 - Other - Babysitter, Female, 38 Year(s)	Lack of Supervision	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:

The ACS documentation reflected there were notes that were not entered contemporaneously, including events that occurred on 3/28/18 and 4/23/18 but was not entered until 5/16/18 and 6/11/18, respectively.

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	☒	☐	☐	☐

Explain:
The father of the babysitter's children said the 15-yo niece and 15-yo CH met with a therapist. This father said he would accept PPRS, but would prefer meeting with the family therapist. The documentation reflected the babysitter's family was offered services, but they declined. ACS engaged the BM and offered bereavement counseling. She declined the services for the family.

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	☐	☐	☐	☐	☐	☒	☐

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:
The SC did not have surviving siblings and there were no other children in the BM and BF's care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM, BF and babysitter's family were offered bereavement counseling. These individuals did not accept the offer for services.

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 in NYS within three years prior to the fatality.

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

The babysitter was not known to the SCR or ACS as a subject.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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