



Report Identification Number: NY-16-017

Prepared by: New York City Regional Office

Issue Date: 8/23/2016

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 year(s)

Jurisdiction: Richmond
Gender: Male

Date of Death: 02/21/2016
Initial Date OCFS Notified: 02/22/2016

Presenting Information

The 2/22/16 SCR report alleged, on 2/21/16 the 17-month-old male child sustained multiple bruises and scratches to his face while in the care of his babysitter. The babysitter was the sole caretaker and person legally responsible for the child during the incident. The babysitter's description of the incident was not consistent with the injuries the child sustained. The babysitter took the child to her home where she cleaned the child and realized he was not breathing. The babysitter then took the child to the MGM's apartment, in the same building as the babysitter's. The MGM and an unrelated household member performed CPR. EMS was called and LE responded.

The 2/22/16 subsequent report alleged, on 2/21/16 at 10:01 PM, first responders were called to the BM's home for an unresponsive one-year-old child. The child was in cardiac arrest with multiple bruises on his head. The child was being cared for by a friend and her male paramour.

Executive Summary

The 17-month-old male child died on 2/21/16. According to the ME's preliminary findings, the child's death was ruled a homicide. The autopsy findings were pending further studies. As of 8/23/16, NYCRO has not yet received the ME's report.

The 2/22/16 SCR reports included the allegations of DOA/Fatality, IG and L/B/W of the child by the babysitter and her male paramour and LMC of the child by the babysitter.

The ACS investigative findings showed the mother left the child in the care of the MGM on 2/19/16. The babysitter agreed to care for the child on 2/19/16. The child remained with the babysitter until 2/21/16, when the babysitter returned the child to the MGM unresponsive. The MGM's unrelated household member called 911 and CPR instructions were provided. The MU performed CPR on the child. The first responders received the 911 call at 10:01 PM. When EMS arrived, the child was observed on the floor and unresponsive. The child was transported to the hospital by ambulance. After repeated unsuccessful attempts to revive him, the child succumbed to his injuries at 11:05 PM.

According to the LE, the mother and MGM were not suspects. LE determined the child was in the care of the babysitter and her paramour for an extended period of time and they were deemed the persons legally responsible (PLR) for the child at the time of the incident. During the LE's interview, the babysitter made inconsistent statements regarding her activities with the child and did not provide adequate explanation for the suspicious injuries the child sustained while in her care. The paramour's statement regarding the events and circumstances that led to the child's death remained constant. The LE obtained evidence; the babysitter was arrested and her paramour was released from LE custody.

ACS visited the MGM's home on 2/25/16. The MGM and the unrelated household member shared a bedroom that was locked and could not be assessed. The room the BM shared with the deceased child had a twin sized bed and crib. Overall, the areas observed were cluttered with bags of clothes. The mother said she spoke with the babysitter

on 2/20/16 and was told that the child was asleep. On the morning of 2/21/16, the babysitter sent a text to the mother and the message implied that the child was well. The mother added that on 2/21/16 at 6:41 PM, the babysitter sent a text that stated the child got a bump on the head. The mother was not concerned since the babysitter said the child was well. There were no concerns related to safety; there were no surviving children in the home or in the care of the mother, MGM, babysitter or paramour. Prior to the incident, the babysitter and paramour's male child was placed in the care and custody of the Commissioner of ACS on 7/3/15 and remained in a foster care placement.

ACS was investigating the 2/22/16 report, when the SCR registered a report dated 2/24/16. The report alleged the BM and the MGM left the child in the care of the babysitter and knew of the babysitter's history. The allegations were IG of the child by the BM and MGM and PD/AM by the MGM. On 4/21/16, ACS unsubstantiated the allegation by the BM and substantiated all allegations by the MGM. ACS noted that the MGM left the child with the babysitter without the BM's permission. The MGM knew of the babysitter's drug history and admitted to drug usage with the babysitter during 2/19/- 2/21/16.

On 6/9/16, ACS substantiated the allegations DOA/Fatality, IG, LMC and L/B/W of the child by the babysitter on the basis that the babysitter made an admission and was incarcerated without bail. ACS substantiated the allegation of IG for the paramour on the basis he was present throughout the weekend with the babysitter and child. There was not enough credible evidence to substantiate the allegations of DOA/Fatality and L/B/W against the paramour. ACS added to the report and substantiated the allegation of IG by the MGM on the basis she left the child in the care of the babysitter.

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



NYS Office of Children and Family Services - Child Fatality Report

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 did not complete the 30-Day Child Fatality safety assessment for the 2/22/16 report.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan 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:	Failure to provide notice of report
Summary:	The SCR report was dated 2/22/16, the NOE was observed to have been provided to the BF on 6/8/16. The NOE was not provided timely to the BF.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan 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: 02/21/2016

Time of Death: 11:05 PM

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

County where fatality incident occurred:

RICHMOND

Was 911 or local emergency number called?

Yes

Time of Call:

10:01 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
- Playing
- Other

- Working
- Eating

- Driving / Vehicle occupant
- Unknown

Did child have supervision at time of incident leading to death? Yes

Is the caretaker listed in the Household Composition? Yes - Caregiver



NYS Office of Children and Family Services - Child Fatality Report

At time of incident supervisor was:

- Drug Impaired
- Alcohol Impaired
- Distracted
- Impaired by disability
- Absent
- Asleep
- Impaired by illness
- Other: non compliant with prescribed medication

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 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	46 Year(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	40 Year(s)
Other Household 1	Other Adult	Alleged Perpetrator	Female	31 Year(s)
Other Household 1	Other Adult	Alleged Perpetrator	Male	53 Year(s)
Other Household 2	Father	No Role	Male	29 Year(s)
Other Household 3	Other Child	No Role	Male	10 Year(s)

LDSS Response

According to LE, the babysitter provided inconsistent accounts of the events. The paramour's statement was consistent and he was released. LE said the SC had suspicious injuries. LE obtained the building's video; it showed the MGM enter the babysitter's apartment on 2/21/16 at 7:34 PM and leave at 8:04 PM. The video showed at 9:58 PM the babysitter carried the limp SC up the stairs. LE informed the Specialist both addresses were monitored and were not deemed crime scenes.

The babysitter admitted she tried to return the SC to the MGM the morning of 2/20/16. However, the MGM asked her to keep him. The babysitter admitted she began to physically abuse the SC around noon on 2/20/16. According to the babysitter, she and the MGM smoked and snorted drugs the night of 2/21/16; while the SC was in the bedroom. It was unclear whether the MGM observed the SC during that time. The babysitter denied the paramour abused the SC during the weekend.

The first responders observed the SC was on the floor, unresponsive, and in full cardiac arrest. EMS took the SC to the hospital. According to EMS, the SC's injuries appeared suspicious.

The ME's preliminary findings showed the SC's injuries included multiple skull and a shoulder fractures, hemorrhage to the brain, back neck muscle, optic nerve, spine and liver. There were abrasions, lacerations and contusions found to the SC's face, eye, tongue, head, liver, back, neck, chest, buttocks, penis, scrotum and toe. The child sustained bruises alongside the abdominal wall. The ME removed a pencil from the SC's anus. The pencil caused tears and perforations to the rectum that caused internal bleeding.



NYS Office of Children and Family Services - Child Fatality Report

A community service provider stated home visits were made for approximately 18 months. There were no indicators of drug use by the MGM or BM; nor concerns regarding the care the SC received at home with the BM or MGM. The last visit was on 12/17/15 and the SC was meeting milestones and there were no observable suspicious marks, or bruises on the SC.

The MGM made conflicting statements regarding the time she gave the SC to the babysitter and the time she met the SC during the weekend. The MGM gave the babysitter the SC on 2/19/16. The MGM admitted she smoked marijuana with the babysitter between 2/19/16-2/21/16. The MGM said she met the babysitter in 2015 and knew of the babysitter's drug use history. The MGM was unaware the babysitter had child welfare history.

According to the BM, the MGM introduced the babysitter to her 4 months prior to 2/21/16. She said she left the SC in the care of MGM on 2/19/16. The MGM told BM the SC was with the babysitter and there was no concern 2/20/16. The BM said the babysitter appeared caring with the SC and only babysat when the BM had no one else. The BM was unaware of the babysitter's CPS history and that the MGM had relapsed.

The paramour said he did not observe the SC in the babysitter's home on 2/19/16. The paramour denied he witnessed the babysitter cause physical harm to the SC. The paramour explained that he often left the babysitter alone with the SC in the home and did not supervise the SC. The babysitter spent a lot of time alone with the SC in the bedroom while the paramour remained in the living room. He noted the SC slept in the bedroom on the bed while he and the babysitter slept on the sofa in the living room. On the night of 2/21/16, the MGM visited the babysitter for approximately 45 minutes. Shortly after, the babysitter took the SC to the MGM's home and returned home and said the SC was not breathing. He went to the MGM's home and observed the MU performing CPR on the SC on top of a table. The paramour said the MGM and the babysitter used drugs together during the period from 2/19/16 to 2/21/16.

According to the MU, the BM left the SC with the MGM. The MU was unsure of the reason the MGM allowed the babysitter to care for the SC. The MU stated the MGM was not an appropriate resource.

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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation
NY-16-017	FINAL		Page 7 of 17



NYS Office of Children and Family Services - Child Fatality Report

			Outcome
025706 - Deceased Child, Male, 1 Yrs	029041 - Grandparent, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
025706 - Deceased Child, Male, 1 Yrs	029741 - Other Adult - Babysitter, Female, 31 Year(s)	DOA / Fatality	Substantiated
025706 - Deceased Child, Male, 1 Yrs	029741 - Other Adult - Babysitter, Female, 31 Year(s)	Lack of Medical Care	Substantiated
025706 - Deceased Child, Male, 1 Yrs	029741 - Other Adult - Babysitter, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
025706 - Deceased Child, Male, 1 Yrs	029741 - Other Adult - Babysitter, Female, 31 Year(s)	Lacerations / Bruises / Welts	Substantiated
025706 - Deceased Child, Male, 1 Yrs	029742 - Other Adult - Babysitter's Paramour, Male, 53 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

On 2/22/16, ACS attempted to conduct an interview and a death scene investigation. ACS was informed by LE that the babysitter's apartment was deemed a crime scene.

Fatality Safety Assessment Activities



NYS Office of Children and Family Services - Child Fatality Report

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Legal Activity Related to the Fatality

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

Family Court

Criminal Court

Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	Fact Finding Description:	Disposition Description:
03/21/2016	There was not a fact finding	There was not a disposition
Respondent:	029742 Other Adult Male 53 Year(s)	
Comments:	A derivative Article 10 Abuse petition was filed against the paramour in Richmond County Family Court on behalf of his and the babysitter's biological male child who had previously been remanded to the care and custody of the Commissioner of ACS. All prior court orders were continued and the placement of the child was continued. The case was adjourned for service.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	Fact Finding Description:	Disposition Description:
03/21/2016	There was not a fact finding	There was not a disposition
Respondent:	029741 Other Adult Female 31 Year(s)	
Comments:	A derivative Article 10 Abuse/Neglect petition was filed against the babysitter in Richmond County Family Court (RCFC) in regards to her and the paramour's biological child who was receiving foster care services. All prior court orders were continued and the placement of her child was continued. The case was adjourned for service.	

Criminal Charge: Murder Degree: 1			
Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
02/23/2016	The babysitter	Pending	unknown
Comments:	As a result of the 2/22/16 investigation, the babysitter was arrested on 2/23/16. The babysitter admitted to LE she had begun to physically abuse the child around noon on 2/20/16 after she tried to return the child to the MGM; however, the MGM asked and the babysitter agreed to continue to care for the child. According to the babysitter, she smoked marijuana while the child was in her care from 2/19/16 to 2/21/16 and snorted heroin the night of 2/21/16, while the child was in the bedroom.		



NYS Office of Children and Family Services - Child Fatality Report

Have any Orders of Protection been issued? Yes

From: 03/21/2016 **To:** Unknown

Explain:
 The Richmond County Family Court issued a Temporary Order of Protection (TOOP) against the babysitter and her male paramour for their biological child as a derivative filing to their child who was receiving foster care services. The paramour was only allowed to have supervised visits with the child.

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 Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:
 The mother declined bereavement service and accepted burial assistance services offered by ACS. The subjects of the report had child who continued to receive foster care services.



NYS Office of Children and Family Services - Child Fatality Report

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 surviving siblings or other children residing in household of the BM or MGM.

The subjects of the report had a surviving child who continued to reside in a foster care placement.

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

Explain:

There were no services provided to the mother.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/08/2015	9979 - Other Child - Babysitter's child, Male, 9 Years	9977 - Other - Babysitter, Female, 30 Years	Parents Drug / Alcohol Misuse	Indicated	Yes
	9979 - Other Child - Babysitter's child, Male, 9 Years	9977 - Other - Babysitter, Female, 30 Years	Inadequate Guardianship	Indicated	
	9979 - Other Child - Babysitter's child, Male, 9 Years	9978 - Other - Babysitter's Paramour, Male, 52 Years	Inadequate Guardianship	Indicated	
	9979 - Other Child - Babysitter's child, Male, 9 Years	9978 - Other - Babysitter's Paramour, Male, 52 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:

The 6/8/15 SCR report alleged, the paramour went to the home of the babysitter and child to pick up some of his



NYS Office of Children and Family Services - Child Fatality Report

belongings. The paramour and babysitter had a verbal altercation that became physical when the paramour punched the mother in the face in the presence of the child. A parent substitute intervened to prevent further domestic violence. The role of the babysitter and parent substitute were unknown.

Determination: Indicated **Date of Determination:** 07/22/2015

Basis for Determination:
ACS substantiated the allegation of IG of the child by the babysitter and paramour (the child's parents) on the basis that the babysitter allowed the paramour to enter the home although there was an active OOP. The parents had a physical altercation in front of the child. The paramour was arrested.

ACS added to the report and substantiated the allegation of PD/AM of the child by the parents. ACS verified the father had a large amount of a narcotic in his possession. ACS previously received positive toxicology tests for the mother. The mother admitted she used marijuana and it had a negative effect on the mother. ACS placed child in a non kinship foster home.

OCFS Review Results:
The ACS staff initiated the investigation within the required timeframe. ACS obtained supporting documentation and information from relevant collateral contacts pertaining to the investigation. The Specialist gathered sufficient information to make determination for all allegations on the intake report. ACS completed the required assessments in a timely manner.

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

Issue:
Failure to provide notice of report

Summary:
The ACS case record did not reflect whether these parents were provided the NOE for 6/8/15 report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
ACS must submit a corrective action plan 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:
Failure to Provide Notice of Indication

Summary:
The ACS case record did not reflect whether the parents were provided notices of indication for the 6/8/15 report.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
ACS must submit a corrective action plan 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:
Timely/Adequate Seven Day Assessment

Summary:
The safety decision selected in the 7-Day Safety Assessment stated one or more safety factors placed the child in immediate or impending danger of serious harm. However, ACS did not identify the safety factor that actually placed the



NYS Office of Children and Family Services - Child Fatality Report

child in immediate danger. ACS initiated safety intervention and the agency conducted a protective removal of the babysitter and paramour's male child.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

ACS must submit a corrective action plan 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:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The safety decision selected in the 7/22/15 safety assessment document stated one or more safety factors placed the child in immediate or impending danger of serious harm. However, ACS did not identify the actual safety factor that placed the child in immediate danger.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(b)

Action:

ACS must submit a corrective action plan 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/18/2015	7781 - Deceased Child, Male, 8 Months	7782 - Mother, Female, 21 Years	Inadequate Guardianship	Unfounded	Yes
	7781 - Deceased Child, Male, 8 Months	7782 - Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:

The 5/18/15 SCR report alleged, on a regular bases, the mother smoked excessive amounts of marijuana and drank liquor to the point of impairment while she was the sole caretaker of the 8-month-old child. On more than one occasion, the mother had blown the inhaled smoke in the child's face and the child inhaled the smoke the mother exhaled. The child had become impaired from the marijuana smoke exposure and passed out. This situation was ongoing.

Determination: Unfounded

Date of Determination: 06/18/2015

Basis for Determination:

ACS unsubstantiated the allegations of INDG and PDRG of the child by the BM. The BM was receiving services with the Healthy Families program at the time of the report. The assigned visiting baby nurse had been visiting the home regularly to assess the child. The nurse did not observe any issues between the BM and BF nor was the BM observed under the influence of marijuana during home visits. The BM denied the allegations of PDRG.

OCFS Review Results:

The ACS staff initiated the investigation within the required timeframe. ACS obtained supporting documentation and information from relevant collateral contacts pertaining to the investigation. The Specialist gathered sufficient information to make determination for all allegations on the intake report in the course of the investigation. ACS completed the required assessments in a timely manner.

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

**Issue:**

Failure to provide notice of report

Summary:

During the review, there was no documentation observed that ACS provided the child's father a NOE.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

ACS must submit a corrective action plan 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:

Review of CPS History

Summary:

There was no review of the mother's or MGM's CPS history documented in the progress notes.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

ACS must submit a corrective action plan 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:

Diligence of Efforts

Summary:

The CONNECTIONS record did not reflect whether ACS made diligent efforts to interview the father.

Legal Reference:

NYCRR 430.12D

Action:

ACS must submit a corrective action plan 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/06/2013	9990 - Other Child - Babysitter's Child, Male, 7 Years	9988 - Other - Babysitter, Female, 28 Years	Inadequate Guardianship	Indicated	Yes
	9990 - Other Child - Babysitter's Child, Male, 7 Years	9989 - Other - Babysitter's Paramour, Male, 50 Years	Inadequate Guardianship	Indicated	
	9990 - Other Child - Babysitter's Child, Male, 7 Years	9988 - Other - Babysitter, Female, 28 Years	Lack of Supervision	Indicated	

Report Summary:

The 7/6/13 SCR report alleged, on 7/5/13, the babysitter and paramour shoplifted and involved their seven-year-old male



child, by having the child walk out of the store with stolen merchandise. The babysitter and paramour were arrested and were unable to make plans for the child's care while they were in custody.

Determination: Indicated

Date of Determination: 08/30/2013

Basis for Determination:

The babysitter left the child home alone for over an hour and 20 minutes without contact with the child. The babysitter admitted she was non-compliant with her treatment which impaired her ability to care for the child. A provider stated the babysitter voices told her to harm herself.

The paramour did not provide the child with proper supervision and guardianship; he allowed the child to be present and actively participate in criminal activity. The stolen possessions were found on the child.

The FSS was opened on 8/9/13. An Article 10 petition was filed on 8/28/13 seeking COS. Treatment and educational PPRS services were provided to the family by the New York Foundling agency.

OCFS Review Results:

The ACS staff initiated the investigation within the required timeframe. ACS obtained supporting documentation and information from relevant collateral contacts pertaining to the investigation. The Specialist gathered sufficient information to make determination for all allegations listed in the intake report in the course of the investigation. The determination made by ACS to indicate the report was appropriate. ACS completed the required assessments in a timely manner.

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

Issue:

Failure to provide notice of report

Summary:

The babysitter and paramour were listed as the subjects of the 7/6/13 SCR report. The NOE was not provided to the BM and BF within the required timeframe.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

ACS must submit a corrective action plan 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:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

According to the 8/28/13 safety assessment document, the selected safety decision stated there were one or more safety factors that potentially placed the child in immediate or impending danger of serious harm. However, ACS did not identify a safety factor that actually placed the child in immediate danger although the agency developed a safety plan for the family.

Legal Reference:

18 NYCRR 432.2(b)(3)(iii)(b)

Action:

ACS must submit a corrective action plan 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.



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

The mother had no CPS history more than three years prior to the fatality.

The babysitter and her male paramour were listed as the subjects of a 7/29/11 report. The allegation of the report was IG of their male child, who was then five years old. ACS unsubstantiated the allegation of the report and the family was referred to Community Based Services.

The paramour was the subject of a 1/4/13 report. The allegations of the report were IG and PD/AM of the paramour and babysitters male child, who was then seven years old. ACS unsubstantiated the allegations of the report.

The MGM was the subject of 12 indicated reports from 2/8/89 through 6/1/98 with reported allegation of B/S, L/B/W, PD/AM, IFCS, IG, LMC, LS and OTH. The MGM's children were remanded and placed in foster care as a result of the investigations. These children are now adults.

Known CPS History Outside of NYS

There was no known CPS history outside of 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?

- Family Court
- Criminal Court
- Order of Protection

Have any Orders of Protection been issued? Yes	
From: 01/06/2016	To: 01/05/2017
Explain: There was an active Order of Protection (OOP) against the mother of the deceased child.	
From: 10/27/2015	To: 10/26/2016
Explain: On 10/27/15, two Temporary Order of Protection (TOOP) were issued against the paramour on behalf of his biological child who remained in a foster care placement.	

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