Report Identification Number: NY-18-015

Prepared by: New York City Regional Office

Issue Date: Jul 30, 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 | **Jurisdiction:** Office Of Special Investigations | **Date of Death:** 02/14/2018

Age: 1 month(s) | **Gender:** Male | **Initial Date OCFS Notified:** 02/14/2018

Presenting Information

The SCR report alleged that on 2/14/18, at around 11:30 AM, the DCP put the SC for a nap. It was unknown where the SC was napping or the condition of the area around the SC. At 11:45 AM, the DCP observed the SC was not breathing. The DCP started CPR on the SC and called 911. The SC was transported to the hospital, where he was pronounced dead at 12:24 PM. The SC had no preexisting health conditions and was an otherwise healthy child. The DCP was the only adult responsible for the SC at the time of his death. The BM had an unknown role.

Executive Summary

This 1-month-old male SC died on 2/14/18. According to the ME's preliminary findings, injuries were excluded as a cause of the SC's death. The SC had no physical signs of abuse or maltreatment and the autopsy was pending further studies. As of 7/30/18, NYCRO had not yet received the ME's report.

The allegations of the 2/14/18 report were DOA/Fatality and IG of the SC by the DCP.

ACS interviewed the DCP regarding the death of the SC. According to the DCP, the SC had attended the DC since 2/6/18. On 2/13/18, the SC did not attend the DC due to a medical appointment. On 2/14/18, the DCP cared for the SC and three other older children; ages 1, 2, and 3 years. At approximately 8:35 AM the BM brought the SC to the DCP' s home. The BM informed the DCP the SC had a cold. The DCP conducted a health check of the SC. The SC appeared well; although the SC was cranky. The DCP did not observe marks or bruises on the SC. The BM informed the DCP the SC was fed a bottle of milk around 7:00 AM and a home remedy tea prior to attending the DC. The BM instructed the DCP to feed the SC the remainder of the tea. The DCP recalled the tea was clear. The DCP fed a small amount of the tea to the SC. The DCP burped and laid the SC on his back in the "infant nest" that belonged to the DCP. The DCP placed the "infant nest" on the sofa. The DCP reported except for a thin blanket on the SC's legs, there were no other items placed in or around the SC sleeping in the infant nest. Of the four children, the SC, 2 and 3-year-old children were asleep on the sofa for about a half hour. The DCP checked SC and noticed he seemed different.

The DCP picked the SC up and noticed he was not breathing. The DCP called 911. The DCP began to perform CPR on the SC and mucus expelled from the SC's nose. Soon after, LE and EMS arrived. EMS took over resuscitative measures and escorted SC by ambulance to Brookdale Hospital. The DCP and the three children were escorted to the hospital by the LE. The DCP telephoned the BM and informed her of the SC's condition and location. The DCP remained in the waiting room with the three other children. The DCP contacted the three other children's parents while she was at the hospital. The BM arrived at the hospital and was with medical staff. The BM informed the DCP of the SC's death. The DCP and the three other children were escorted to her home by LE; however, they could not enter as LE and the ME were in the process of conducting their respective investigations. As a precaution, the DCP advised the parents of the three other children to take their children to the physician.

ACS assessed the DCP's home. The DCP cared for the children on a large sectional sofa in a large living room on the first floor of the case address. The 2-year-old child was a relative of the DCP and resided at the case address; however, the DCP was not the primary caretaker. ACS verified that there were no children in the primary care of the DCP. There were no safety issues observed.

During the investigation, ACS gathered pertinent information from significant collateral contacts, observed the DCP's apartment, obtained statements from the parents, LE, ER and the Department of Health and Mental Hygiene (DOHMH). ACS assessed the safety of the SS and the three other children in their respective homes. All children appeared healthy and free of marks and bruises. There were no hazardous conditions observed. The children were deemed safe.

On 4/10/18, ACS substantiated the allegation of IG of the SC by the DCP on the basis the DCP was the sole caretaker of four children on the date the SC died. The DCP was not licensed by the DOHMH to provide child care services at the time of the SC's death; therefore, the DCP was not monitored by the agency as a child care provider.

ACS unsubstantiated the allegation of DOA/Fatality of the SC by the DCP on the basis of a lack of evidence that the SC died as a result of abuse/maltreatment.

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:
No safety assessment were required as the DCP no longer cared for children.

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:
At the time of closure, there were no children in the care of the DCP. All children were assessed as safe with their respective primary caretakers.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/14/2018 **Time of Death:** 12:24 PM

Time of fatal incident, if different than time of death: 11:45 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 11:45 AM
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:

- [x] 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? No
If the child was in day care at the time of the fatality, was the day care program duly licensed or registered? 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	1 Month(s)
Deceased Child's Household	Father	No Role	Male	44 Year(s)
Deceased Child's Household	Mother	No Role	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	66 Year(s)

LDSS Response

On 2/14/18, LE deemed the DCP's home a crime scene. The infant nest (in which the SC had been placed to sleep) was taken into evidence. LE arrived at the scene at 11:49 AM and observed EMS performing CPR on the infant. LE escorted the DCP and the three other children in her care to the hospital; while EMS took the SC in the ambulance. There was no suspicion of child abuse.

According to the BF, on the incident date the BM breastfed the SC before she left to take the SC to the DCP. The BF said the SC looked healthy and appeared fine. The SC began attending the DC this week and he had not met the DCP.

On 2/14/18, the BM said she fed the SC a whole bottle. The BM stated the SC was still fussy, so she breastfed him to calm him down. Shortly thereafter the SC appeared happy and was smiling. She said she took daily photos of the SC. ACS observed a photo of SC sitting up in the chair. The BM said she gave him a home remedy tea to ease the sniffles. The BM provided a bottle of a home remedy tea and told the DCP to give it to the SC if needed. The BM stated the SC was healthy and received routine medical examination on 2/13/18. The BM stated the SC was normal and did not have a cold. The SC was not prescribed medication. The BM stated she was interested in a DCP who would be able to pay attention to the SC. The SS attended a DC with 12 children and the BM did not feel the SC would get needed attention. The BM learned of the DCP through a friend. The BM noticed the DCP cared for two children older than the SC and was unaware the DCP was an unlicensed provider. The BM stated the DCP called her at approximately 12:03 PM regarding the SC's condition. The BM went to the hospital.

On 2/14/18, ACS assessed the SS. There were no suspicious marks or bruises observed on the SS. The SS appeared to have received a minimum degree of care. There were no safety hazards observed in the home. According to the DCP's adult daughter who resided in the home, she was not in the home at the time of the incident. She said she was at work, when the DCP called her about the SC's condition. She stated the DCP cleaned and sanitized the toys and living room area every night and stayed with the children in the living room area.

On 2/14/18, attending physician stated that the SC arrived in the ER at 11:59 AM and was pronounced dead at 12:24 PM. The ER staff attempted to revive the SC although the SC appeared to have been dead for an hour. There were no observable signs of abuse/maltreatment on the SC. The ME stated an autopsy results were pending further studies. Upon physical examination, there was no evidence of child abuse/maltreatment observed. The SC's body showed no marks or bruises on any part of his body.

On 2/15/18, DOHMH confirmed the DCP was not a licensed provider. The DCP failed to re-enroll as a Legally Exempt provider under Women's Housing and Economic Development Corporation (WHEDCO) and her home was subsequently closed on 11/26/17.

On 2/16/18, EMS stated the 911 call was received at 11:45 AM. EMS arrived on scene at 11:49 AM and observed the DCP with the SC in her arms attempting CPR. EMS continued resuscitative measures. The SC was in cardiac arrest when EMS arrived. EMS left the scene at 11:52 AM with the SC. The DCP and the three other children were taken to the hospital by LE.

On 2/22/18, ACS visited the SS DC. The SS attended the site since she was an infant. The SS DCP stated the SS was developing well and there were no concerns.

On 2/22/18, ACS held a Child Safety Conference (CSC). The parents did not accept ACS invitation to participate in the CSC. During the CSC, ACS determined Family Court intervention was not required.

On 2/26/18, SC's PCP stated the SC was last seen on 2/13/18 for concerns of congestion and irritability. The examination revealed the SC had a normal appearance and was not in distress. The SC received immunization and no medication was prescribed.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
044381 - Deceased Child, Male, 1 Mons	046704 - Day Care Provider, Female, 66 Year(s)	DOA / Fatality	Unsubstantiated
044381 - Deceased Child, Male, 1 Mons	046704 - Day Care Provider, Female, 66 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				

Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☐	☐	☒	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
The subject of the investigation was the DCP. The SS was not in the care of the DCP at the time of the SC's death.

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:
ACS offered the parents bereavement, funeral/burial arrangements, EI and play therapy services. The parents declined all 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?	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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

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

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 had no 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.

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the provider comply with discipline standards?	☐	☐	☐	☒
Was a Criminal History check conducted? **Date:** 03/20/2018	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:**	☐	☒	☐	☐
Was a check completed through the Staff Exclusion List? **Date:**	☐	☒	☐	☐

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