Child Fatality Report

Report Identification Number: NY-18-067

Prepared by: New York City Regional Office

Issue Date: Dec 19, 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: 9 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 06/19/2018
Initial Date OCFS Notified: 06/19/2018

Presenting Information

On 6/19/18, a report was registered with the SCR concerning the death of the SC. The report stated that on 6/14/18, the daycare provider shook the 9-month old SC and as a result he sustained a subdural hematoma and multiple retinal hemorrhages. On 6/19/18, the SC succumbed to his injuries. The mother, aunts, and cousins were listed on the report, but with no roles.

Executive Summary

The SC was 9 months old when he died. As of the writing of this report, the ME had not confirmed the cause of death. OCFS had not received the autopsy report.

The SC resided with his mother and other maternal relatives; the father resided in his native country. The mother had no other children. The father had children who he reported were in the care of their MGM in his native country .

At the time of the SC's death, there were two open investigation dated 6/14/18 involving the injuries that led to the SC's death. One investigation listed the mother as the subject and the other listed the babysitter (BS).

On 6/19/18, the SCR registered a report with allegations of DOA/FATL, II and IG of the SC by the BS.

The initial reports noted the SC was with a daycare provider; however, after consulting with the Department of Health (DOH), it was confirmed that the BS had applied for a day care license and it was in process. Aside from the SC and the BS' child, there were no other children in the home.

According to ACS' investigations on 6/14/18, the BS reported the SC began having seizures before she contacted 911. However, the SC did not suffer from this condition. EMS responded to the 911 call and the SC was transported to Jamaica Hospital and placed on a ventilator; hours later he was transported to Cohen's Children Medical Center (CCMC) where he remained in critical condition and subsequently died on 6/19/18.
Medical staff determined the SC's injuries were consistent with Shaken Baby Syndrome (SBS). The mother was ruled out by the NYPD as a person of interest; based on the time line of events leading to the 911 call. Based on the information reported to the medical staff, it was determined the SC would have exhibited symptoms prior to coming into the BS's care, if he had been shaken by the mother. On 6/18/18, the BS was arrested and charged with Assault in the 1st Degree; she was granted bail for her release. The criminal case is pending, but the BS had not admitted to hurting the SC.

On 6/18/18, ACS held a Child Safety Conference (CSC) concerning the BS's child; present were the child's father and the MGPs. As a result of the conference, ACS filed an Article 10 Abuse Petition. The Queens Count Family Court (QCFC) released the BS's child to her father with court ordered supervision (COS) and an order of protection (OOP) was issued against the BS. The BS's child was medically cleared.

Despite ACS' efforts, to obtain information from the DA and the NYPD regarding updates on the criminal court case; no information was provided. Therefore, it is unknown whether additional charges were added against the BS after the SC's death. ACS had minimal contact with the mother after the BS's arrest.

The documentation of the fatality investigation did not reflect that ACS continued with their investigation as relevant

contacts were not made. It was not clear what information the BS provided to the NYPD or the ADA that led to her arrest. The documentation with the ME did not contain a discussion of the information gathered or confirmed what parties had been interviewed by the ME.

As of the writing of this report, ACS has not made a determination on the fatality report.

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?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
The mother had no other children. ACS properly assessed the safety of the BS's daughter and took court action against the BS.

Was the decision to close the case appropriate? Unknown

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The report is undetermined.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	There were lapses in the casework documentation by the CPS unit concerning the investigation stemming from a an apparent miscommunication between ACS' CPS unit and the Family Service Unit.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	ACS made relevant collateral contacts but did not engage in significant discussion concerning medical or legal issues. ACS could have also contacted the BS's previous employees and parents of the children she cared for at her former daycare.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/19/2018 **Time of Death:** Unknown

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

County where fatality incident occurred: Queens
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? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 5 Minutes
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	9 Month(s)
Deceased Child's Household	Mother	No Role	Female	32 Year(s)
Deceased Child's Household	Other Adult - MGC	No Role	Female	26 Year(s)
Deceased Child's Household	Other Adult - MGC	No Role	Female	23 Year(s)
Deceased Child's Household	Other Adult - MGA	No Role	Female	60 Year(s)

Other Household 1	Other - Baby sitter (BS)	Alleged Perpetrator	Female	023 Year(s)
Other Household 1	Other Child - BS's daughter	No Role	Female	9 Month(s)

LDSS Response

On 6/14/18, ACS contacted the NYPD who indicated the medical staff determined the SC's injuries were consistent to SBS or being in a car accident. The NYPD examined the BS's car and there was no sign of an accident. The NYPD noted the BS reported the SC began to exhibit symptoms of distress at about 10:00 A.M. which was about four hours after she picked up the SC from the mother. The NYPD ruled out the mother as the person of interest as the SC was in the BS's care at the time of the incident.

ACS contacted Jamaica Hospital and learned the SC arrived at the hospital at 10:30 A.M. The SC was not breathing and was unresponsive; he was placed on a ventilator. A CAT-scan revealed the SC had multiple subdural hematomas, and his prognosis was poor.

ACS interviewed the BS who said she began caring for the SC on 5/28/18; and he would often come to her home with a bad cough "like he was panting". The BS stated on 6/1/18 the SC was very sick and the mother agreed to meet her at the pediatrician where her (BS) child was seen. The BS said she heard the mother say the SC was on medication, but the mother had not made her aware the SC was prescribed medication. The BS said on 6/14/18, she picked up the SC around 5:50 A.M. and he "did not look well"; he was pale. The mother told the BS the SC had not slept well. The BS said she arrived at her home with the SC and placed him on a playmat made of foam in the living room. The BS said the SC threw up a little after she fed him. The BS said at 7:30 A.M the SC began to cry so she put him to sleep, and at 8:00 A.M. he woke up. The BS placed the SC on the mat to play, and then she put him in the "baby jumper" for a bit. The BS said the SC then started to cry a little and did not want to be in the "baby jumper" any longer so she moved him to the play on the mat. At this time, the BS' child woke up so she placed her on the mat with the SC. The BS said she sat in between the children while they played. The BS said the SC was playing and suddenly he began to shiver. The BS stated she began to ask the SC whether he was okay and he smiled at her, but about five minutes later he was shivering more severely. The BS stated she knew the SC was seizing so she put him on his side so that he could "throw up" and saliva was coming out of his mouth. The BS said she called 911 at about 10:12 A.M. and then called the mother and inform her of the incident. The BS said the SC was still breathing when EMS arrived at the scene.

The BS stated she cared for the SC on 6/13/18 from 6:00 A.M. through 9:00 P.M. and he was fine. The BS said the SC played all day and did not take a nap as the mother requested that she not allow the SC to nap, so that he could sleep throughout the night. The BS stated the SC did not fall and did not have an accident while in her care. The BS said she was neither frustrated nor overwhelmed from caring for the children as she had experience caring for a large group of children at her previous day care.

ACS met with the medical team at CCMC who determined the SC showed symptoms of SBS and explained the seizures would have begun within just a few minutes of the SC being shaken. Based on the time line provided by the mother and the BS, the medical staff determined the SC could not have gone hours without exhibiting any noticeable signs of distress. ACS made no inquiries about the SC's appearance and discomfort noted by the BS prior to the seizures.

ACS interviewed the mother who confirmed the information provided by the BS concerning the SC's health and stated she had stopped giving the SC the prescribed medication once he began to feel better. ACS contacted the BS's and the SC's pediatricians who also confirmed the BS's account concerning the SC's health. The SC pediatrician noted the SC had been treated for respiratory issues, but he had no concerns about the SC's overall condition. The SC was healthy and his immunizations were up to date.

The determination for this report is pending

Official Manner and Cause of Death

Official Manner: Unknown
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: Case documentation did not reflect a joint investigation with an MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047051 - Deceased Child, Male, 9 Month(s)	048661 - Other - Baby sitter (BS), Female, 023 Year(s)	Inadequate Guardianship	Pending
047051 - Deceased Child, Male, 9 Month(s)	048661 - Other - Baby sitter (BS), Female, 023 Year(s)	DOA / Fatality	Pending
047051 - Deceased Child, Male, 9 Month(s)	048661 - Other - Baby sitter (BS), Female, 023 Year(s)	Internal Injuries	Pending

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 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 SC's mother refused services, but the BS accepted mental health and parenting skills services.				

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: The babysitter's child was removed based on an Article 10 petition filed against her mother, the BS.				

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:**
06/18/2018	There was not a fact finding	There was not a disposition
Respondent:	047052 Day Care Provider Female 23 Year(s)	
Comments:	ACS filed and Article 10 Abuse Petition against the BS concerning her child. The Queens Family Court released the BS's child to the child's father. An OOP was issued against the BS, and the judged granted her supervised visit with her child.	

Criminal Charge: Assault **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Babysitter	Pending	Pending
Comments:	The BS was arrested on 6/16/18 and charged with Assault. Although the SC died on 6/19/18, as of the writing of this report, ACS had not updated information to confirm whether additional charges would be added.		

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: The OOP was granted at the initial hearing and has continued.	

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 early intervention for the BS's child.

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? Yes
Explain:
The SC had no surviving sibling in NYS and there were no children residing in his home.

The BS had a child for whom ACS filed an abuse petition listing the BS as the respondent. ACS released the child to her father. ACS continued COS of the BS's child. Bereavement, EI and daycare services were offered to the BS's father.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the mother, but it was unknown whether she followed up on the with the referral information.

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?	Yes
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?	Yes

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/14/2018	Deceased Child, Male, 9 Months	Mother, Female, 32 Years	Inadequate Guardianship	Pending	No
	Deceased Child, Male, 9 Months	Mother, Female, 32 Years	Internal Injuries	Pending	

Report Summary:
The SC was with the BS who called 911 after he began having seizure and became unresponsive. The SC was transported to the hospital; intubated with irregular blood pressure, no brain stem, unresponsive, and a poor prognosis. The SC was admitted to the hospital with subdural hematoma and severe anoxic brain injury.The mother had no explanation for the SC's injuries.

The SC also had visible bruising to the forehead; which were allegedly sustained on 6/11/18 after being hit on the head with a block. This explanation was not plausible.

The BS was charged with the SC's injuries.

Report Determination: Unfounded | **Date of Determination:** 08/08/2018

Basis for Determination:
The allegations of II and IG were unsubstantiated against the mother as ACS cited the SC was in the care of the BS when he began having the seizures. Medical staff diagnosed the SC sustained bilateral multiple subdural hematoma and a severe anoxic brain injury; and multiple retinal hemorrhages which lead to his demise. The ACS cited the BS was arrested and charged with Manslaughter.

OCFS Review Results:
ACS investigation included collaterals to obtain relevant information concerning the reported incident. The safety

assessments were completed properly as the SC had no surviving sibling. The documentation reflected that ACS properly assessed the safety of the BS's child even though the child resided in a separate household. This included a CSC and the filing an Article 10 Abuse Petition. During this investigation ACS maintained contact with the NYPD and medical staff who ruled out the mother as a person of interest in connection to the death of the SC.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/14/2018	Deceased Child, Male, 9 Months	Other - Babysitter, Female, 23 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 9 Months	Other - Babysitter, Female, 23 Years	Internal Injuries	Substantiated	

Report Summary:
The SCR registered a report stating the SC was hospitalized with a subdural hematoma and a severe anoxic brain injury. The report noted the SC was intubated with irregular blood pressure, no brain stem, unresponsive, and a poor prognosis. The report also stated the BS had contact with the SC and had no explanation for the SC's injuries.

Report Determination: Indicated **Date of Determination:** 08/08/2018

Basis for Determination:
ACS substantiated the allegation of II and IG of the SC by the BS. ACS cited that medical examinations revealed the SC sustained bilateral multiple subdural hematomas, a severe anoxic brain injury and multiple retinal hemorrhages while in the BS's care. ACS also cited the SC died as a result of his injuries' and the BS was arrested in connection to his death.

OCFS Review Results:
ACS conducted a thorough investigation; but were unable to engage the NYPD or the ADA to provide information concerning the BS's charges after the SC's death. ACS conducted interviews with the mother and the BS who noted the BS picked up the SC from the mother's home at about 6:00 A.M. Based on the medical examination, the SC's injuries were consistent with SBS and the time frame of events as reported by the BS revealed the SC was injured while in her care. ACS filed an Abuse Petition against the BS for her child and released the child to her father. An OOP was issued against the BS and visits with the child were to be supervised by ACS or the father.

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

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

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

Known CPS History Outside of NYS

Family had no known CPS history outside 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