NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-15-004 **Prepared by: Spring Valley Regional Office**

Issue Date: 10/6/2015

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	MN-Medical Neglect	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: 3 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 01/15/2015
Initial Date OCFS Notified: 01/15/2015

Presenting Information

On 1/14/15, while in the babysitter's home and in her care, the three-month-old subject child was found to be unresponsive by the babysitter. The subject child was asleep for over three hours. It is unknown if the child was checked on that timeframe. The babysitter ran to the neighbor's house and the neighbor called 911. The subject child was transported to the hospital in cardiac arrest and was transferred to another hospital in critical condition. On 1/15/15, the subject child passed away at the hospital. The subject child was an otherwise healthy child and the cause of death is unknown, which makes the death suspicious. The parents have unknown roles.

Executive Summary

On 1/14/15, the New York Statewide Central Register of Child Abuse and Maltreatment received a report regarding the three month old subject child (SC). The report alleged that the SC became unresponsive and sustained brain swelling while in the care of the babysitter. On 1/15/2015, the SCR received a subsequent report with allegations of DOA/Fatality and Inadequate Guardianship against the babysitter on behalf of the SC. The babysitter had been caring for the SC regularly since 12/15/2014. The SC resided in the home with the mother, father and thirteen-year-old half sibling.

The report was assigned to Suffolk County Department of Social Services (SCDSS) and the department coordinated their investigation with law enforcement. The SCDSS assessed the safety of the parents' home and determined the surviving sibling was safe to remain in the care of her parents. The SCDSS attempted to conduct a safety assessment of the babysitter's son; however, SCDSS was denied entry into the babysitter's home by her attorney. SCDSS was prohibited from interviewing the babysitter's son as well due to the pending criminal investigation; however, the SCDSS had interviewed the son prior to their knowledge of the legal conditions. The 12 year old son denied having any concerns with the manner in which the babysitter (his mother) cared for him and the SC.

SCDSS gained access to the babysitter's home on 3/6/2015 and safety factors were not present. The future risk of maltreatment was assessed to be low. All necessary collateral contacts were made.

SCDSS' investigation established the SC was in good health prior to the incident. On the day of the incident, the mother followed a normal routine in caring for the SC. She nursed the SC prior to transporting the SC to the babysitter's home around 6:45 A.M. The SC was asleep upon the mother's arrival and, consequently, she left him in his car seat at the babysitter's home. The parents acknowledged that they were aware the babysitter did not have a bassinet or crib in her home for the SC. The SC slept in the car seat carrier while in the babysitter's care. The babysitter had broken her mobile phone; consequently, the mother provided the babysitter with an operable mobile phone a few days prior to the inicident . The babysitter did not activate the phone. Around 12:00 P.M., the babysitter used the neighbor's phone to contact the mother to inform her that the SC was not breathing. Emergency Services responded and transported the SC to the hospital where he died a day later. The babysitter did not travel with the SC to the hospital. The attending doctor diagnosed the SC with a swollen brain, indicating he lacked oxygen. There were no other injuries observed.

The ME's report was pending at the time of the writing of this report.

The allegation of DOA/Fatality and Inadequate Guardianship were unsubstantiated regarding the babysitter. SCDSS found no evidence to support that the babysitter's actions resulted in the SC's death. The SCDSS and the local law enforcement made attempts to locate the babysitter after the incident. The babysitter retained an attorney who declined to allow the agency or law enforcement to interview the babysitter due to the pending homicide investigation. OCFS found that the investigation was conducted appropriately and agrees with the determination.

SCDSS did not find evidence in the initial report to support the allegations of Inadequate Guardianship and Internal Injuries against the babysitter on behalf of the SC. The ME confirmed there were no existing or preexisting injuries noted to the SC's body. Without the babysitter's cooperation, details of the events surrounding the incident are unknown.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The CW made several attempts to interview the babysitter prior to case closure. The SCDSS made a determination based on the information they were able to obtain.

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:
The investigation conclusion was conducted appropriately. The babysitter did not avail herself for an interview.

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: 01/15/2015 **Time of Death:** 08:14 PM

Date of fatal incident, if different than date of death: 01/14/2015
Time of fatal incident, if different than time of death: 12:30 PM

County where fatality incident occurred: SUFFOLK
Was 911 or local emergency number called? Yes
Time of Call: 12:42 PM
Did EMS to 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
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Unknown if they were impaired.

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	3 Month(s)
Deceased Child's Household	Father	No Role	Male	37 Year(s)
Deceased Child's Household	Mother	No Role	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Other Household 1	Other	Alleged Perpetrator	Female	44 Year(s)
Other Household 2	Other Child	Alleged Victim	Male	12 Year(s)
Other Household 3	Other	No Role	Female	24 Year(s)

LDSS Response

The Suffolk County Department of Social Services (SCDSS) initiated the investigation within 24 hours of receipt of notification. The SCDSS contacted all necessary collaterals and gather pertinent information. Despite several attempts, the SCDSS did not have the opportunity to interview the babysitter. SCDSS learned from law enforcement that the babysitter secured legal representation. The babysitter's whereabouts became unknown on the day of the incident. The SCDSS in collaboration with law enforcement, interviewed the babysitter's 12 year old son at his school. The 12 year old son denied any domestic violence or substance abuse in the home. He reported being sick and home from school at the time of the incident; however, denied having any knowledge of the circumstances surrounding the incident. The 12 year old son did not report any concerns regarding how the babysitter cared for the SC. The son stated the SC would always sleep in his infant car seat at his home. SCDSS conducted interviews with the parents of the SC in the presence of the local law enforcement. The parents corroborated each other's account of the day of the incident. The parents' household had age appropriate and adequate provisions for the SC. The parents confirmed they were aware that a bassinet or crib was not available in the babysitter’s home for the SC; and he slept in the car seat carrier. The parents stated they believed the babysitter had other provisions for the SC. The parents reported the SC was behaving normally prior to going to the babysitter and was a healthy baby.

The CW reviewed medical records and documented that the SC was healthy and current with having received two required immunizations shortly before his death. The CW made contact with the social worker, physician and medical examiner. The CW also interviewed the maternal grandmother and first responders. The ME reported there were no current or past injuries observed for the SC. At the time of the report the final autopsy report was still pending.

All Safety Assessments, as well as the Risk Assessment Profile were completed appropriately, timely, and accurately reflected the known circumstances of the case. The SCDSS accurately assessed the presence of safety factors throughout the life of the case and adequately intevened when necessary.

Prior to the conclusion of the investigation, the babysitter's attorney granted the SCDSS access to the babysitter's home. The babysitter was not present, and a family member escorted the SCDSS into and throughout the home. There were no safety concerns noted for the babysitter's son. All age appropriate provisions were observed. A crib or bassinet was not observed in the home.

SCDSS accurately determined the allegations within the prescribed timeframe. The allegations of DOA/Fatality and Inadequate Guardianship were unsubstantiated regarding the babysitter. SCDSS did not find evidence to support the babysitter was negligent resulting in the SC's death.

The allegations of Inadequate Guardianship and Internal Injuries listed on the initial report dated 1/14/15 were unsubstantiated. SCDSS did not gather any evidence to support the babysitter's actions caused injury to the SC.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Comments: Diligent efforts were made by SCDSS to contact the alleged subject; however, she could not be located after the subject child became unresponsive. The babysitter later obtained an attorney who refused to allow SCDSS and law enforcement to interview the babysitter due to the open homicide investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
018061 - Deceased Child, Male, 3 Mons	018081 - Other - friend, Female, 44 Year(s)	DOA / Fatality	Unsubstantiated
018061 - Deceased Child, Male, 3 Mons	018081 - Other - friend, Female, 44 Year(s)	Inadequate Guardianship	Unsubstantiated
018082 - Other Child - Friend's child, Male, 12 Year(s)	018081 - Other - friend, Female, 44 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☒	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

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	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The surviving child was referred to bereavement and mental health counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

Bereavement counseling was provided to the family.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/23/2012	3465 - Other - child, Male, 9 Years	3464 - Other - caretaker, Female, 42 Years	Inadequate Guardianship	Unfounded	No

Report Summary:
On 5/23/2012, Suffolk County Department of Social Services (SCDSS) received a report from the SCR regarding the babysitter's nine-year-old son. The allegation of Inadequate Guardianship was made against the babysitter. The report alleged that the babysitter left her then nine-year-old son to care for his severely disabled adult sibling while the mother worked overnight.

Determination: Unfounded | **Date of Determination:** 07/12/2012

Basis for Determination:
SCDSS found no evidence to support that the babysitter left the son unattended to care for his adult disabled sister. It was documented that the babysitter used the maternal aunt as a resource to supervise and care for the then nine-year-old son and adult sibling while she worked. The babysitter identified other family members that act as resources in supervising

her children in her absence.

OCFS Review Results:
The case record did not reflect that the maternal aunt whom the babysitter identified as a resource to supervise her then nine-year-old son and the adult sibling was located and interviewed to corroborate the babysitter's account. All other collateral contacts were attempted and successful.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/12/2012	3468 - Other - child, Male, 9 Years	3467 - Other - caretaker, Female, 42 Years	Childs Drug / Alcohol Use	Unfounded	No
	3468 - Other - child, Male, 9 Years	3467 - Other - caretaker, Female, 42 Years	Lack of Supervision	Unfounded	

Report Summary:
On 12/12/12, SCDSS received a report from the SCR regarding the babysitter's then nine-year-old son. There were allegations of Lack of Supervision and Parent's Drug/Alcohol Misuse made against the babysitter. The report alleged the babysitter was an alcoholic and left her then nine-year-old son home alone with an adult sibling who is disabled. The report alleged she was intoxicated and unable to care for her children.

Determination: Unfounded **Date of Determination:** 01/28/2013

Basis for Determination:
The CW documented that the babysitter denied the allegations as well as the then nine-year-old son. SCDSS' review of the school, medical, and law enforcement records, as well as unannounced visits to the home did not uncover evidence to support the allegations.

OCFS Review Results:
SCDSS' obtained the necessary release forms to gather information from collateral contacts; however, the documentation did not reflect inquiries with the family members regarding how the son and adult sibling were supervised in the event of the mother's absence.

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

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

There were (2) SCR reports generated more than three years before the fatality. On 7/14/2001, SCDSS received a report from the SCR alleging Inadequate Guardianship against the mother and father of the half-sibling who was one month old at the time. The report alleged that the parents of the then one month old half-sibling were in a verbal altercation which led to the father throwing the one month old half-sibling from his arms to a bed and kicked the mother in the ribcage. On 8/8/2001, SCDSS substantiated the allegations against the parents. No services were required.

On 8/9/2004, SCDSS received the second report from the SCR regarding the subject child's mother on behalf of the mother's eldest child who was three year old at the time. The allegation of Inadequate Guardianship was made against the mother and the father of the then three year old half-sibling. The report alleged that the father hit the mother with his hand while the mother was holding the then three year old half-sibling. On 8/24/2004, the allegation was substantiated against the parents. The case remained open with court ordered services.

Known CPS History Outside of NYS

No known 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

In the report dated 8/9/2004, a petition was filed against the parents and the case remained open for services. The family service stage was opened on 8/16/2004. The father was ordered to complete a domestic violence program, parenting skills and an order of protection to refrain from domestic violence. The case remained open until April 18, 2009. The father completed parenting and domestic violence program. The child remained with the mother.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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? 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