Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-056

Prepared by: New York City Regional Office

Issue Date: Nov 09, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 05/10/2021
Initial Date OCFS Notified: 05/10/2021

Presenting Information

The SCR registered a report alleging that on 5/9/21 at 5:00 PM, the BM dropped off the four-month-old subject child at the daycare provider's (DCP) home. The DCP kept the SC overnight as planned. On 5/10/21, between 3:00 PM and 4:00 PM, the DCP checked the SC and discovered him unresponsive in the crib. She called 911 immediately and he was transported by EMS to a hospital where he remained unresponsive; he had no visible injuries. Despite being an otherwise healthy child, he was pronounced dead at 4:21 PM. The DCP was unable to provide an explanation for the SC's death.

Executive Summary

This fatality report concerns the death of a four-month-old male who was in the care of a DCP for the first time. The subject child had no surviving siblings. The BM dropped the SC off at the DCP's home on 5/9/21at 5:15 PM for an overnight stay. The BM received a call on the following day at 3:38 PM that the SC had been taken to the hospital. She arrived at the hospital and the DCP told her the SC was asleep in the crib and when she checked she discovered him cold to the touch; she called a friend who summoned EMS and the SC was transported to the hospital. The BM was called into a room to speak to the attending Dr who then informed her of the passing of her son. The DCP had left the ER when the BM returned to ask what had happened.

ACS learned from the hospital staff that the SC was found with a cracked rib that was caused by applying CPR and a small scratch that EMS reported was accidental. The ME had concerns regarding safe sleep as the SC was found with blankets in the crib which was not aligned with safe sleep practices which played a role in the SC's death. The ME also noted that the SC appeared to have been face down for an extended period. LE found no criminality and closed their case. ACS learned from the NYC Department of Health and Mental Hygiene that the DCP was an unlicensed provider. The DCP had not been known to the SCR or ACS.

ACS learned from the DCP she had been providing care since 2016 and she had not experienced any incidents or child deaths. At the time of the incident, the DCP had been providing care to three children that included the SC, an infant and a toddler. The DCP said the BM told her the SC had just begun to roll over and she should watch him closely. The DCP reported she checked on the SC every ten minutes.

The BM reported she visited the DCP's home a few weeks prior, to assess the home. She confirmed she observed the DCP had been providing care to other children; however, she did not ask whether the DCP was licensed. The SC was up to date with immunizations, and he had no medical conditions. ACS verified this information with the pediatrician. The BM had no other children and the BF resided out of state.

On 7/9/21, ACS substantiated the allegation of DOA/Fatality and IG of the SC by the DCP. ACS found that the DCP failed to properly supervise the SC which led to him face down for an extended period. ACS cited the ME preliminary findings and concerns regarding unsafe sleep.

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

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

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: 05/10/2021 **Time of Death:** 04:21 AM

Time of fatal incident, if different than time of death: 03:30 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 03:30 PM
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? 1 Hours

At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **Unknown**

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	4 Month(s)
Deceased Child's Household	Mother	No Role	Female	35 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	54 Year(s)

LDSS Response

The SCR registered a report with information that alleged the SC died while in the care of the DCP and it was unknown whether the DCP was a person legally responsible for the SC. The ACS CPS responded to this fatality within the required timeframe by contacting the NYC DOMHH, hospital staff, LE, ME, the BM, and DCP. The DOMHH reported the DCP was not licensed. The DCP declined a face-to-face interview; however, she spoke to ACS on the phone on 5/11/21. ACS noted that the BM and DCP had no SCR or ACS history and the DCP had no criminal history. All interviews were completed with the assistance of an interpreter.

The hospital staff reported they found no suspicious, visible signs that indicated abuse or neglect of the SC. The ME reported the SC was found with no internal injuries and had no medical conditions. The SC was placed on his back to sleep and was found face down as he had begun to roll over. The ME reported there were indications the SC was face down for an extended period and there were concerns regarding unsafe sleep conditions, as two blankets were found in the crib. The cause of death was unknown as the final autopsy was pending. LE reportedly found no criminality and closed their case.

The BM told ACS that she dropped the SC off at the DCP on 5/9/21 at 5:00 PM for an overnight stay. Soon after, the DCP texted her a picture that showed the SC being fed and he was doing well. On the following day at 10:00 AM, the BM received a text stating the SC was doing well. It was approximately 3:00 PM when the BM received a phone call stating the SC felt cold and was taken to the hospital. The SC's last well-baby visit with the pediatrician occurred on 4/30/21 and he received vaccinations that had no negative effect. ACS verified the information with the pediatrician who also stated the SC had no medical conditions. The BM stated the DCP was referred to her by a friend. The BM had no other children and the BF resided in another state.

At the time of the phone interview with the DCP on 5/11/21, the DCP stated she was not feeling well and was staying with a friend; she did not disclose her exact whereabouts. The DCP said she put the SC in the crib, face up, to nap after 3:00 PM. She said she checked on him twice, and the third time she found him unresponsive. She called a friend whose son called 911 for her as he spoke English; the friend accompanied her to the ER. The DCP reported she had been providing care to four other children with no set schedule. At the time of the incident, there were children ages two years old and four years old in the home.

On 5/13/21, ACS assessed the children and deemed them safe in their parents' care who reported no concerns regarding the

care the DCP provided.

On 5/14/21, ACS visited the DCP's address and viewed the room in which she provided daycare services; it was empty, she had relocated with no forwarding address. The landlord rented the room to the DCP since November 2020, and was not aware the apartment was used for an unlicensed daycare; there were no concerns or complaints regarding the DCP.

On 7/9/21, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the DCP citing the results of their investigation. ACS wrote that the DCP failed to properly supervise the SC which led to the SC being face down for an extended period in an unsafe sleep area. ACS noted there were blankets found in the crib. ACS cited the ME's preliminary findings that noted the pooling of blood found on the SC's neck was consistent with the SC being found face down and there were concerns around unsafe sleep surface due to the blankets. ACS noted that such conditions did not align with safe sleep policies and played a role in the death of the SC.

Official Manner and Cause of Death

Official Manner: Pending
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)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058624 - Deceased Child, Male, 4 Mons	058626 - Day Care Provider, Female, 54 Year(s)	DOA / Fatality	Substantiated
058624 - Deceased Child, Male, 4 Mons	058626 - Day Care Provider, Female, 54 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?	☒	☐	☐	☐
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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No