Child Fatality Report

Report Identification Number: NY-20-115

Prepared by: New York City Regional Office

Issue Date: Jun 16, 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: 8 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 12/16/2020
Initial Date OCFS Notified: 12/16/2020

Presenting Information

The SCR report registered on 12/16/20 alleged the eight-month-old female subject child died of unknown reasons. On 12/16/20, the father left the subject child at the babysitter's home at about 8:20AM. In the late morning or early afternoon, the babysitter put the subject child down for a nap. The sleeping arrangements were unknown. This was the last time the subject child was seen alive. The babysitter checked the subject child about thirty minutes after she put her down for a nap and noticed the subject child was sweaty, hot to the touch, and unresponsive. The babysitter consequently contacted the father and called 911. The father arrived at the babysitter's home and he accompanied the subject child in the ambulance to the hospital. The subject child arrived at the hospital at 2:36PM in cardiac arrest. CPR was in progress. There was no spontaneous breathing and the subject child was pronounced dead at the hospital at 3:06PM. The babysitter had no explanation as to how the subject child died. The babysitter was responsible for the care of the subject child at the time of her death.

Executive Summary

The 8-month-old female subject child died on 12/16/20. As of the writing of the OCFS report, NYCRO had not received a copy of the autopsy report. There are no surviving siblings or other children in the family's home. At the time of the child's death the child was in an unlicensed day care setting.

On 12/16/20, a report was registered with the SCR with the allegations of DOA/Fatality and Inadequate Guardianship of the subject child by the day care provider and her assistant.

Upon receipt of the report, the Administration for Children's Services initiated the investigation by contacting pertinent collaterals including the medical staff at the hospital where the child was taken, the NYC Department of Health, law enforcement, the Medical Examiner, and EMS.

ACS's investigation revealed on 12/16/20 the day care provider had nine children, including her biological child, in her care. The child arrived at the provider's home at about 8:20AM. The child's father reported the child had been a little "fussy" and provided medication for the child. At around 8:37AM, the provider prepared a bottle and the subject child took two sips. The subject child refused her medication. At around 9:00AM, the provider placed the child in the Pack-n-Play then checked the child about 9:30AM and she was fine. The subject child awoke at around 10:00AM. At about 11:20AM, the subject child went back to sleep and the provider placed the child on her stomach in the Pack-n-Play. She gave the subject child her blanket and left the door half-way open. At about 12:15PM, the provider checked the subject child and again she seemed fine. At 2:10 PM, the child was found unresponsive. The provider placed the subject child on the floor and began to perform CPR. The provider's seven-year-old child called 911. EMS arrived shortly after and transported the child to the hospital. The provider called the father and her assistant. When the assistant arrived, she contacted the other parents to retrieve their children.

Throughout the investigation ACS maintained contact with the appropriate collaterals. On 12/17/20, LE informed ACS the death of the subject child did not seem to be suspicious.

On 2/14/21, ACS substantiated the allegations of Inadequate Guardianship of the subject child by the provider. ACS documented the provider placed the subject child to sleep in a separate room without a direct line of sight while she cared for eight other children unassisted. ACS did not use the fact that the provider placed the child face down in the Pack-n-

Play and added a blanket to the sleep surface as part of the decision to substantiate the allegation.

ACS unsubstantiated the allegation of DOA/Fatality by the provider and the assistant. ACS documented the child's death certificate did not reflect a definitive cause and manner of death. Additionally, the investigation did not reveal any information that the provider or assistant caused the death of the subject child.

The allegation of Inadequate Guardianship against the assistant was also unsubstantiated on the basis of no credible evidence to support the allegation. ACS documented the assistant worked with the provider to care for the children; however, on the day of the incident the assistant did not have childcare responsibilities as she was not at work.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Casework activity was commensurate with case circumstances

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:
NA

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

Child Fatality Report

Date of Death: 12/16/2020 **Time of Death:** 03:06 PM

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? N/A
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
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 was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☒ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ Other:

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	Female	8 Month(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	No Role	Female	34 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	38 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	50 Year(s)

LDSS Response

On 12/16/20, ACS interviewed one of the providers. ACS noted the provider resided at the case address with her seven-year-old male child. ACS documented there were no concerns with the provider's child.

ACS observed a Pack-n-Play that was used for the subject child to sleep. The provider explained the father brought the subject child to her home and shortly after the father left the subject child fell asleep. At about 11:20AM, the provider said she placed the subject child, face down, in the Pack-n-Play, and the subject child turned her face to the side. The provider said she placed a blanket next to the subject child. The provider said the subject child made herself comfortable and continued to sleep. The provider said she then left the room to prepare lunch and checked the subject child at 12:15PM. The child appeared fine. The day care provider said she received a phone call which lasted about twenty minutes. At the

end of the call she checked the subject child and noticed the child's hair was wet; the subject child was sweating profusely, her lips were blue, and she was unresponsive. The provider said she lifted the subject child, brought her to the living room, and initiated CPR while the provider's seven-year-old-child called 911 for emergency medical assistance. The provider said she called the assistant to remove the other children from the area, and then called the subject child's father to notify him of the incident and that the subject child was not responding. In a later interview, the provider said the father had informed her the subject child was not feeling well and had provided medication to be given to the child if she became "fussy." The provider indicated she had received training regarding Safe Sleep for infants.

On 12/16/20, the day care provider's assistant said she did not work the day of the incident, but the day care provider called her at 2:16PM to come over. When she arrived, EMS and law enforcement officers were there with the subject child. The assistant said she took the children from the area, including the day care provider's seven-year-old child, and called parents to retrieve them. The assistant said she was unsure of what had occurred prior to her arrival. The day care provider's seven-year-old child said he felt scared and that the subject child died in his apartment.

On 12/17/20, ACS interviewed the father. The father said the subject child last saw the pediatrician on 12/15/20 during a telehealth visit. The subject child was prescribed medication and was receiving the medication as prescribed. ACS confirmed the child had been seen by a medical provider and was prescribed medication.

The father said he had given the day care provider the medicine for the subject child. Regarding the day of the incident, the father said he woke up with the subject child at 6:30AM. The subject child appeared happy. The father said he took the subject child to the day care provider sometime between 8:20AM and 8:40AM, and later received a call from the day care provider telling him about the child's condition. The parents said the subject child began being cared for by the day care provider in September 2020. The parents expressed wanting referrals for grief counseling and any support groups of parents who had experienced similar trauma.

On 12/18/20, ACS contacted the hospital where the child was taken. The emergency room physician stated on the day of the incident the hospital received notification at 2:30PM that an eight-month-old child would be arriving. The physician said upon arrival, the child had no pulse, was blue, and her extremities were cold. The physician stated that the emergency room team tried for thirty minutes to resuscitate the child; however, this was to no avail and the child was pronounced dead.

On 12/17/20, ACS interviewed law enforcement officers and the information obtained from the officers regarding the parents' statement was consistent with the information the father had provided to ACS.

On 12/21/20, ACS received a report from the agency through which the day care provider was employed. According to the report, during the time of the incident, the day care provider had a total of nine children (ages eight months old to seven years old) in her care; the seven-year-old child was the day care provider's child. The other eight children were all unrelated. All the children were in the day care provider's care Monday through Friday during various hours except for a two-year old child who attended Monday through Thursday. The NYC Department of Health issued a cease and desist letter to the provider for immediate discontinuance the operation as the provider was unlicensed. By the end of the investigation ACS confirmed no children remained in her care.

Between 12/21/20 and 2/10/21, ACS continued to make contact with the appropriate collaterals. No new information was received. ACS contacted the families of the children who had been in the day care provider's care. None of the parents had any concerns regarding the care the day care provider had given to the children in her care.

The assigned NYPD detective confirmed the day care provider had no criminal history, and that law enforcement's investigation was ongoing pending the Medical Examiner's findings. ACS received the child's death certificate which stated the subject child's cause of death was pending further studies.

ACS unsubstantiated the allegation of DOA/Fatality of the subject child by the day care provider and the assistant on the basis of no credible evidence. ACS documented the child's death certificate did not reflect a definitive cause and manner of death. Additionally, the investigation did not reveal any information that the provider caused the death of the subject child.

ACS substantiated the allegation of Inadequate Guardianship of the subject child by the provider. ACS documented the provider placed the subject child to sleep in a separate room without a direct line of sight while she cared for eight other children unassisted.

The allegation of Inadequate Guardianship against the assistant was unsubstantiated on the basis on no credible evidence to support the allegation. ACS documented the assistant worked with the provider to care for the children; however, on the day of the incident the assistant did not have childcare responsibilities.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057101 - Deceased Child, Female, 8 Mons	057121 - Day Care Provider, Female, 50 Year(s)	Inadequate Guardianship	Unsubstantiated
057101 - Deceased Child, Female, 8 Mons	057104 - Day Care Provider, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
057101 - Deceased Child, Female, 8 Mons	057104 - Day Care Provider, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
057101 - Deceased Child, Female, 8 Mons	057121 - Day Care Provider, Female, 50 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐

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: On 2/8/21, the parents signed up for therapy.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents sought trauma counseling on their own.

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? 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

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.

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the provider comply with discipline standards?	☐	☐	☒	☐
Was a Criminal History check conducted? **Date:** Unknown	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 12/17/2020	☒	☐	☐	☐
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