Child Fatality Report

Report Identification Number: NY-19-047

Prepared by: New York City Regional Office

Issue Date: Nov 04, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased

Jurisdiction: Office Of Special Investigations

Date of Death: 05/07/2019

Age: 4 month(s)

Gender: Male

Initial Date OCFS Notified: 05/07/2019

Presenting Information

On 5/7/19, the SCR registered a report that alleged DOA/Fatality and IG of the SC by the Day Care Provider (DCP). The report alleged that On 5/7/19, between 11:30 AM and noon the BF dropped the SC off at the home of the DCP. At approximately 2:00 PM, the BF returned to pick up the SC and when the DCP went to get the SC out of the bouncy seat, she observed the SC to be unresponsive. The BF administered CPR while the DCP contacted 911. EMS responded and continued resuscitation efforts while they transported the SC to Bronx Lebanon Hospital (BLH). The SC was pronounced dead at 2:46 PM on the same day.

Executive Summary

On 5/7/19, the SCR registered a report regarding the death of a four-month-old male child (SC) that occurred at the home of a DCP. The report alleged DOA/fatality and IG of the SC by the DCP. ACS received information from the BLH, EMS and LE that confirmed the SCR report.

On 5/8/19, the ACS Specialist observed the New York City Department of Health and Mental Health inspector provide the DCP with a Cease and Desist order of operation. According to ACS' case documentation, the DCP stated she is not running a formal daycare and she had no license although she had been providing care for ten years. The care was provided to a community of people from the same "home land" and they helped each other when necessary. The DCP stated the SC had been in her care for four days including the day of the incident and he showed no signs of illness. At the time of the incident, there were two other children present in the home, an eighteen-month-old who arrived at the daycare at approximately 9:00 AM and a three-year-old who arrived at 10:00 AM, on that morning. Those children were deemed safe and the parents of those children had no concerns for the care the DCP provided to their children; they stated they are close like family.

The BF worked nights and usually provided care to the SC during the day while the BM was at work. The SC was breastfed only and it was routine for the BM to go home to nurse the SC. The BM last nursed the SC at 8:00 AM on the morning of the incident, just before she left home. The BF had an errand to run so he left the SC with the DCP at 11:00 AM and returned for him at 2:00 PM. The SC was alert at that time.

ACS learned from the attending Dr. that the SC arrived at the ER unresponsive. The Dr. reportedly found no marks or bruises on the SC's body that indicated maltreatment or abuse. The SC was pronounced dead at 2:46 PM. According to the FDNY, they received two 911 calls for emergency medical assistance for a four-month-old male.

ACS learned from Lincoln Hospital that the SC received routine care there and in January of 2019, he was examined in the ER and released. ACS interviewed the parents of the SC separately; they both reported the SC was their only child and he had no medical conditions. They disclosed no incidents of DV, mental illness or drug use. Due to their beliefs, the parents initially did not agree to have an autopsy performed; however, to find out the cause of their son's death, they permitted the autopsy. The ME final autopsy report listed the cause and death of the SC undetermined.

On 7/4/19, ACS substantiated the IG allegation stating there was some credible evidence to support the allegation. ACS documented the DCP placed the four-month-old in a bouncy chair and did not monitor the SC as needed, due to his age. The DCP failed to display proper guardianship. The DCP was providing daycare services to children and did not have the

appropriate child care license. ACS unsubstantiated the allegation of DOA/fatality of the SC by the DCP, citing a lack of credible evidence. ACS reported they consulted with the medical staff and LE and found no evidence that the death was caused by the DCP.

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

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 decision to close the case was appropriate.

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: 05/07/2019 **Time of Death:** 02:46 PM

Time of fatal incident, if different than time of death: 02:10 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 02:10 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? 2 Hours
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	4 Month(s)
Deceased Child's Household	Father	No Role	Male	42 Year(s)
Deceased Child's Household	Mother	No Role	Female	39 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	31 Year(s)

LDSS Response

ACS initiated the investigation in a timely manner on 5/7/19 by visiting the daycare where the incident occurred. The ACS Specialist interviewed the DCP who stated she has no license to provide care to children; however, she had been babysitting for ten years. She explained that friends referred her to their friends, and she helped by babysitting even though there were times that she received no monetary compensation. She provided care in her home from Mondays thru Fridays. She cared for three siblings ages 10, 8 and 6 years on weekdays from 2:30 PM to 6:00 PM. She also provided care to two other children ages three and eighteen-months, when their parents required her services. The DCP resided in her home with her spouse and their three children, eighteen-months, six and twelve years of age.

On the day of the incident, the DCP had been providing care to four children, her eighteen-month-old, a three-year old, a one-year-old child and the SC. According to the DCP, the SC was in her care for only four days; she observed him to be a “nice baby, not fussy.” She took the SC from the BF, moved him from his stroller and placed him in a bouncer seat. She placed the seat on the living room floor between the sofa and the entertainment stand. The DCP was busy with the three other children while the SC slept. The children were on the other side of the living room watching TV and did not touch the SC. The DCP stated "she heard the SC whine," and when she checked on the SC he was fine. She was not aware of the time she checked but stated that it was closer to the time he arrived. When the BF arrived, the DCP went to dress the SC when she discovered him unresponsive. She took him to the BF and called 911. The operator instructed the BF to initiate CPR until EMS arrive. The DCP left the surviving children with the neighbor and rode in the ambulance with the SC.

ACS interviewed EMS who reported they received a call at 2:10 PM from the DCP requesting emergency medical assistance for a four-month-old male. At 2:14, a second 911 call was registered; it was the BM and she reported the BF had informed her the SC was unresponsive. EMS transported the SC to BLH emergency room where he was pronounced DOA by medical staff.

ACS interviewed LE who said they arrived at the home at the same time with EMS. LE observed the SC laying on a blanket, on the floor. The BF was in the process of performing CPR. The SC appeared blue in color, his tongue was pale/white with no excretion; there was nothing obstructing his mouth. LE found no criminality and closed their investigation.

ACS interviewed the BLH staff who reported similar information in the report narrative and the account of LE. ACS received medical documentation from Lincoln Hospital where the SC received routine medical care, he was last examined in the ER on 1/18/19; he was released. The parents missed the appointment for 4/15; and rescheduled for 5/8/19.

ACS interviewed the SC's parents separately. They both reported the SC was a healthy and happy child. The parents opted for an autopsy despite their religious beliefs. The parents reported two of their babies died during child birth when they were in their native country.

ACS interviewed the parents of the surviving children and the DCP's neighbors and they reported they had no concerns of care the DCP provided.

On 7/4/19, ACS indicated the IG allegation stating some credible evidence to support the allegation was found. ACS wrote that the DCP placed the four-month-old in a bouncy chair and did not monitor the SC as needed, due to his age. The DCP failed to display proper guardianship. The DCP was providing daycare services to children and did not have the appropriate child care license. ACS unsubstantiated the allegation of DOA/fatality of the SC by the DCP, citing a lack of credible evidence. ACS reported they consulted with the medical staff and LE and found no evidence that the death of the SC was caused by the DCP.

Official Manner and Cause of Death

Official Manner: Undetermined
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)?No
Comments: The ACS investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051772 - Deceased Child, Male, 4 Mons	051783 - Day Care Provider, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
051772 - Deceased Child, Male, 4 Mons	051783 - Day Care Provider, Female, 31 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?	☒	☐	☐	☐
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?	☐	☒	☐	☐

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:
The ACS case documentation did not reflect any referrals or information given to the parents or the DCP; however, the DCP had completed a parenting guidance skills workshop on 10/24/15.

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:
The parents had no other children. The DCP's child who was present in the home at the time of the incident was one-year-old and not of age to be interviewed. That child was assessed safe and remained in the DCP's home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The ACS case documentation does not reflect the parents were offered services.

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? 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
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

☒ Was not noted in the case record to have any of the issues listed

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

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

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

On 12/9/14, the SCR registered a report that alleged the DCP slapped her seven-year-old daughter in her face as a form of discipline. The seven-year-old sustained bruises to her left cheek and lip. ACS investigated the allegations of LBW, XCP and IG of the seven-year-old by the DCP. On 2/7/15, ACS unsubstantiated the allegation of LBW citing a lack of evidence to support the allegation. However, ACS indicated the allegations of XCP and IG citing some credible evidence was found. A scratch was found on the child's cheek. The DCP explained that the inappropriate discipline was due to the her daughter's educational performance. Both parents and the child received parenting training and the seven-year-old was placed in after school tutoring to improve academic performance. The DCP completed a Parenting Guidance Skills Workshop on 10/24/15.

Known CPS History Outside of NYS

There is 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