Child Fatality Report

Report Identification Number: NY-20-098

Prepared by: New York City Regional Office

Issue Date: Mar 27, 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	

Case Information

Report Type: Child Deceased

Jurisdiction: Office Of Special Investigations

Date of Death: 10/22/2020

Age: 1 year(s)

Gender: Male

Initial Date OCFS Notified: 10/22/2020

Presenting Information

Today, 10/22/20, the subject child passed away while in the care of daycare assistants. The subject child was put down for a nap in a pack n play between 12:30 PM and 1:00 PM. Around 3:08 PM, the day care assistant found the subject child on the floor unconscious and not breathing. At this time, one of the assistants contacted the owner of the day care rather than calling 911. It was unknown what position the subject child or the pack n play was in when the subject child was found. It was unknown if the subject child had any visible injuries at this time. An assistant began performing CPR on the subject child. The daycare assistants did not contact emergency services until 3:14 PM resulting in a six minute delay. Initially, upon contacting emergency services, an assistant stated that a large stroller fell on top of the subject child's neck rendering the subject child unconscious. Later, the assistants provided a different explanation of the subject child falling out of the Pack-n-Play resulting in the subject child becoming unconscious.

Executive Summary

The 1-year-old male child (SC) died on 10/22/20. The autopsy report listed the cause of death as neck and chest compressions and the manner as accident (found pinned beneath stroller).

At the time of the incident, the child, along with three other unrelated children ages 1 year old (female), 11 months old (male), and 5 months old (female), were being cared for in a daycare setting by two assistants.

At about 1:00 PM, the children were placed down for nap time. Each child was placed in a separate playpen and the subject child’s playpen was towards the rear of the room. During naptime, the day care assistants took turns every 15 minutes to check the children. At one point between the checks, a noise was heard coming from the nap room. One of the assistants “peeked” into the room and saw the 1-year old female awake in her playpen. The assistants did not enter the nap room. At around 3:00 PM, one of the assistants entered the nap room to wake the children, and as she bent down to pick up the 1-year old female, she saw the subject child laying on his back on the floor with the handle of the six-seater stroller on his neck. The assistant immediately removed the stroller from the child’s neck and carried him into the living room. When the assistant reached the living room, the subject child was placed on the floor and the assistants began CPR. One assistant recalled observing a line on the subject child’s neck and his lips were purple. The assistant called the owner and told her there was an incident with the subject child. She was instructed to call 911. The 911 operator instructed staff to continue CPR. While staff performed CPR, the daycare owner arrived and continued CPR. EMS arrived, performed CPR, and transported the subject child to the hospital where he was pronounced dead.

Case documentation reflected ACS made the appropriate collaterals which included law enforcement, the ME, and the attorney for the family as the family had requested the attorney to speak on their behalf. The family members were not currently staying at the home and were not willing to meet with ACS, but would cooperate with the investigation any other way.

ACS substantiated the allegations of Lack of Supervision by the assistants, Inadequate Guardianship of the child by the daycare owner, and indicated the 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?** 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:
There were no SS's or other CHN in the household.

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: 10/22/2020 **Time of Death:** 04:30 PM (Approximate)

Time of fatal incident, if different than time of death: 03:00 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 03:14 PM
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? Yes
Licensing/Registering Agency: Department of Health and Mental Health Hygiene
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	1 Year(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Deceased Child's Household	Mother	No Role	Female	23 Year(s)
Other Household 1	Other - Day Care Assistant 1	Alleged Perpetrator	Female	23 Year(s)
Other Household 2	Other - Day Care Assistant 2	Alleged Perpetrator	Female	22 Year(s)
Other Household 3	Day Care Provider	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

Upon receipt of the report, the Specialist contacted law enforcement and learned there would not be any arrests as the child's death appeared to be the result of an accident. According to detectives, at 1:30 PM, the assistants heard the children making noise, so they went into the room and saw the children were fine. The assistants were supposed to check the children every 15 minutes, but they checked them every 30 minutes. The last check before the child was found, was completed at 2:30 PM. At 3:00 PM, the assistant entered the room again and saw the SC was under the stroller and playpen. The stroller was on the SC's neck and playpen was over the stroller. The assistant performed CPR, called the daycare owner, and then 911 after being directed to do so by the owner.

According to the detectives, the room in which the subject child was found, had six playpens. The subject child's playpen was in the middle of the room. The playpen had a hole in the mesh and seemed to have been located close to the stroller that was folded against the wall.

On 10/23/20, the NYC Department of Health and Mental Health Hygiene (DOHMH) provided information regarding the daycare. The DOHMH liaison stated the daycare was licensed as a Group Family DC and in December 2019 and January 2020, the owner was issued citations for a violation due to inadequate supervision. ACS learned a letter of revocation was issued; however, the owner was still able to operate during the revocation.

ACS was informed that as a consequence of the fatality, the owner's day care license would be suspended. Later, the DOHMH said although the day care owner was not present when the incident occurred, the staff to children ratio was adequate as there were four children with two staff.

On 10/23/20, the day owner said she was out of state when she received calls from staff that something was wrong with the subject child. She told staff members to call 911 and perform CPR. When she arrived at the daycare, the assistant who called was in the living room performing CPR while receiving instruction from 911. She took over CPR and noticed the child's lips seemed to be purple. EMS arrived after and continued resuscitative efforts.

According to the owner, the assistant stated the subject child did not get out of the playpen; however, she heard a noise, went into the nap room, and saw the SC on the floor at which time she called to him. When the subject child moaned, she picked him up, carried him into the living room, and began CPR. The assistant said she saw the handle of the six-seater stroller on the SC's neck and was in shock. The owner said she called the SC's parents and told the mother there was an accident involving the child and that EMS was at the daycare.

The assistant said that prior to the arrival of EMS, the owner also performed CPR. The stroller was usually stored in the nap room; it was kept in the right corner of the room next to the door. The playpens were not next to the location where the stroller was stored. The assistant said she believed the subject child may have gotten out of the playpen and somehow the stroller fell on him. The stroller was very heavy and could not understand or explain how it could had fallen on the child. The assistant said the child had not climbed out of the playpen before.

On 10/23/20, another assistant said on the day of the incident a noise came from the nap room. She said staff "peeked" in the room to make sure the children were fine; no one entered the nap room to check. The assistant said only the 1-yo female child seemed to be awake. At around 3:00 PM, an assistant entered the nap room to wake the children, and when called, the subject child did not respond. The assistant picked up the child, carried him into the living room and CPR was initiated. The owner was contacted, and staff were told to call 911. This assistant confirmed details regarding the size of the stroller and its storage space.

On 10/23/20, ACS received correspondence from OCFS Division of Child Care informing the program's license/registration had been suspended and revoked.

For the remainder of the investigation ACS made contact with the daycare owner and staff, and the family. No new information was obtained. The family hired an attorney and asked that the attorney represent them in contacts with ACS.

On 12/21/20, ACS unsubstantiated the allegation of DOA/Fatality by the DC owner and the assistants. ACS also unsubstantiated the allegation of Lack of Medical Care by the assistants based on the information learned during the investigation. ACS documented there was no credible evidence to support the allegation of DOA/Fatality.

ACS substantiated the allegations of Lack of Supervision by the assistants and substantiated the allegations of Inadequate Guardianship of the child by the daycare owner. ACS documented that staff did not enter the room, walk around, or check each child to ensure their immediate safety when they heard the noise. ACS documented the assistants failed to provide "line of sight" supervision of the child.

On 3/19/21, the autopsy report was received. The ME listed the cause of death as neck and chest compression and the manner of death as Accident (found pinned beneath stroller).

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)?No
Comments: The case documentation did not reflect there was an MDT response.

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
056433 - Deceased Child, Male, 1 Yrs	056438 - Day Care Provider, Female, 33 Year(s)	DOA / Fatality	Unsubstantiated
056433 - Deceased Child, Male, 1 Yrs	056436 - Other - Day Care Assistant 1, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
056433 - Deceased Child, Male, 1 Yrs	056437 - Other - Day Care Assistant 2, Female, 22 Year(s)	DOA / Fatality	Unsubstantiated
056433 - Deceased Child, Male, 1 Yrs	056438 - Day Care Provider, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
056433 - Deceased Child, Male, 1 Yrs	056436 - Other - Day Care Assistant 1, Female, 23 Year(s)	Lack of Medical Care	Unsubstantiated
056433 - Deceased Child, Male, 1 Yrs	056436 - Other - Day Care Assistant 1, Female, 23 Year(s)	Lack of Supervision	Substantiated
056433 - Deceased Child, Male, 1 Yrs	056437 - Other - Day Care Assistant 2, Female, 22 Year(s)	Lack of Medical Care	Unsubstantiated
056433 - Deceased Child, Male, 1 Yrs	056437 - Other - Day Care Assistant 2, Female, 22 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:
The attorney obtained by the family informed ACS that ACS could forward the Health Insurance Portability Accountability Act documentation to him and a request would be made to the parents to obtain the medical records.

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	☐	☐	☐	☐	☐	☒	☐

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 SS's or other children in the family's household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS did not offer services such as bereavement counseling or burial assistance.

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

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:** 10/23/2020	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 10/22/2020	☒	☐	☐	☐

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