NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-056 **Prepared by: New York City Regional Office**

Issue Date: 12/31/2015

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: New York
Gender: Male
Date of Death: 07/13/2015
Initial Date OCFS Notified: 07/13/2015

Presenting Information

According to the narrative of the SCR report, at approximately 11:55 A.M. on 7/13/15, the day care provider (DCP) noticed the SC was fussing but failed to address his needs and left him in the crib until approximately12:10 P.M. When she checked, the infant appeared pale and lifeless and his lips appeared blue. It was reported the DCP failed to call 911 in a timely manner and the infant was pronounced dead on 7/13/15, at the hospital.

Executive Summary

On 7/13/15, the SCR registered a report alleging the death of a three-month-old male infant in an unlicensed daycare facility. The allegations of the 7/13/15 report were DOA/Fatality, IG and LMC of the SC by the DCP.

Following the receipt of the report, the New York City Department of Health and Mental Hygiene (DOHMH) initiated an investigation into the licensing of the daycare program. The investigation revealed that the DCP had been operating an unlicensed daycare center from her five bedroom residence which she occupied with her family. DOHMH learned that she provided care to fifteen children ages three months to three years since 2001. On 7/14/15, DOHMH issued a Cease and Desist order to the owner. As a result of their investigation, the facility was closed.

ACS initiated an investigation into the death of the three-month-old child and made contact with LE, EMS and the ME. ACS learned that the ME found no signs of maltreatment or abuse of the child. LE reported they found no criminality and closed their case. ACS learned from EMS that they arrived at the daycare at 12:20 P.M. on 7/13/15 and transported the SC to Lenox Hill Hospital where he was pronounced dead at 1:35 P.M.

ACS also interviewed the DCP, three of her staff and other collaterals. On 7/13/15, the DCP reported that the parents and the SC arrived at 9:30 A.M. and as they left, the BM stated she would return to nurse the SC at lunchtime. The DCP stated the SC was fussing and she attempted to soothe him using different methods; however, he still appeared to be in some discomfort. At approximately 10:30 A.M. she fed him two ounces of the mother's breast milk and attempted to burp him, but he did not burp or vomit. She then placed him on his back in a portable bassinet for a nap. At approximately 11:55 A.M., the SC was fussing; however, not crying and she left him in the bassinet as she was preparing for lunchtime. At 12:10 P.M., she noticed the SC appeared pale, his lips were blue, and there was froth excreting from his mouth. She stated that she initiated CPR while yelling for someone to call 911 for medical assistance. She then followed the instructions given by the operator. The BM arrived at the case address during the commotion of the incident and fainted at the sight of the SC. The DCP's statements remained consistent throughout the investigation.

ACS interviewed the parents of the fourteen other children who were receiving care from the facility at the time of the incident. There were no concerns reported. None of the parents reported knowing that this was an unlicensed facility. The daycare staff reported they had no complaints.

The ME autopsy report listed the cause and manner of the SC death undetermined. The SC's parents declined all requests for interviews and all services; the SC's immunizations were up to date.

The daycare center ceased operation on 7/13/15.

On 9/8/15, ACS substantiated the allegation of IG but based their determination on the fact that the DCP was not licensed to operate the program, rather than any action or inactions on the part of the DCP. ACS misapplied the legal standards for maltreatment in making the determination on this report. Not having a license to operate a day care program, in and of itself, is not maltreatment. ACS needed to address the failure to exercise a minimum degree of care, impairment or imminent risk of impairment and causation with respect to this child; however, ACS did not.

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:
ACS and DOHMH completed a thorough investigation into the death of this child.

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:
ACS reviewed the necessary documentation pertinent to the investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS misapplied the legal standards for maltreatment in making the determination on this report. Not having a license to operate a day care program, in and of itself, is not maltreatment. ACS needed to address the failure to exercise a minimum degree of care, impairment or imminent risk of impairment and causation with respect to this child.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date

	of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/13/2015 **Time of Death:** 11:55

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 12:15 AM
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
How long before incident was the child last seen by caretaker? 45 Minutes
Is the caretaker listed in the Household Composition? No
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 supervisor was: Not 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	003 Month(s)
Deceased Child's Household	Father	No Role	Male	41 Year(s)
Deceased Child's Household	Mother	No Role	Female	41 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	53 Year(s)

LDSS Response

On 7/13/15, ACS responded to the report registered by the SCR regarding the death of a three-month-old male infant. ACS obtained information from the first responders, ME, day care provider (DCP) and her staff. According to the documentation, this was the SC's first day at the Soho Daycare. ACS learned that the Daycare was an unlicensed facility which had been in existence since 2001. The daycare center was operated out of the residence of the owner/provider. The DCP, her husband, mother-in-law and three of their six children also resided in the home. The daycare facility was located on the second floor of a converted loft building. It consisted of five bedrooms. The daycare facility was found to be cluttered with deplorable, unsanitary conditions; the carbon and smoke detectors were not working, and it had no fire escape.

The DCP reported that the parents and the SC arrived at 9:30 A.M. and as they left, the BM stated she would return to nurse the SC at lunchtime. The DCP stated that after the mother left, the SC was fussing and she attempted to soothe him using different methods; however, he still appeared to be in some discomfort. At approximately 10:30 A.M. she fed him two ounces of the mother's breast milk and attempted to burp him, but he did not burp or vomit. She then placed him on his back in a portable bassinet to nap. At approximately 11:55 A.M., the SC was fussing; however, not crying and she left him in the bassinet as she was preparing for lunchtime. At 12:10 P.M., she noticed the SC appeared pale, his lips were blue and there was excretion from his mouth. She stated that she initiated CPR while yelling for someone to call 911 for medical assistance. She then followed the instructions given by the operator. The DCP said BM arrived at the case address during the commotion and fainted at the sight of the SC. EMS responded at 12:20 P.M. and transported the SC to Lenox Hill Hospital where he was pronounced dead at 1:35 P.M. on 7/13/15. The ME reported there were no signs of abuse or maltreatment.

According to the case documentation, at the time of the incident, the DCP's 17-year-old daughter was in her room when she heard the DCP call for help and saw her administering CPR. She reported the children were eating lunch and seemed oblivious to the events.

ACS interviewed three daycare staff who had been working with the DCP for 14 years, 5 years and 5 months respectively. The staff reported the DCP cared for the children; they had no complaints. ACS spoke to neighbors who were aware of the child's death and they had no new information to provide.

ACS interviewed the parents of all other children who attended the daycare; none of the parents had any concerns. The SC's parents declined to be interviewed; the SC's health record revealed that his immunizations were current.

The DCP admitted to operating the facility without a license and that she provided care to fifteen children ages three months to three years. She was not related to any of those children. She denied mental health issues, drug usage or DV for herself and her staff. She declined bereavement services.

The DOHMH visited the Soho Daycare premises on 7/13/15 and on 7/14/15, and documented violations which included but were not limited to: worn out play pens, no nap provisions for the older children, and absence of ventilation in the nap rooms. Based on their investigation DOHMH issued a Cease and Desist order to the daycare provider, who was operating without a license for 14 years.

On 8/13/15, LE reported they found no criminality and closed their case and on 9//815 DOHMH reported that subsequent visits to the address indicated the facility was not in operation.

On 9/8/15, the allegation of IG was substantiated against the DCP as she failed to obtain a license to operate the daycare. The allegations of DOA/Fatality and LOMC were unsubstantiated. The report was indicated and closed.

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: OCFS does not have an approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
023101 - Deceased Child, Male, 003 Month(s)	022948 - Day Care Provider, Female, 53 Year(s)	Lack of Medical Care	Unsubstantiated
023101 - Deceased Child, Male, 003 Month(s)	022948 - Day Care Provider, Female, 53 Year(s)	DOA / Fatality	Unsubstantiated
023101 - Deceased Child, Male, 003 Month(s)	022948 - Day Care Provider, Female, 53 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

ACS reviewed the necessary documentation pertinent to the investigation. ACS received the information from the New York City Department of Health and Mental Hygiene (DOHMH) regarding the daycare facility and the SC's public health record.

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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Records pertaining to the child's death were reviewed via the CONNECTIONS database.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents refused services.

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

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

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

The daycare provider was the subject of two indicated reports dated 11/5/96 and 12/3/97, and one unsubstantiated report 6/11/08. In the first report dated 11/5/96, the allegations of "Other" PD/AM were registered against the provider's sister-in law, who was visiting the provider's home. The sister-in-law admitted to cocaine and marijuana use up to two days prior to giving birth. The allegation of "Other" was inadvertently substantiated against the provider. The provider requested an Administrative Review and Fair Hearing in 2009; however, the determination remained as the request was not timely.

On 11/15/96, a neglect petition was filed and the provider was awarded custody of her sister-in-law's newborn. The mother of the child filed for a modification of the order on 7/15/97 and ACS began a COI regarding the issue. On 12/3/97, during a visit to the home for the COI, the newborn was found to have suffered 2nd degree burns on her neck from hot cider. The ACS Specialist called for emergency medical assistance and the child was taken to the hospital for treatment. A SCR report was registered alleging the guardians failed to seek medical attention in a timely manner. The allegations of the report were Burns and Scalding, LOMC, LOS, and IG of the child by the mother of the child. The provider, although she had legal custody of the child, was not immediately named as a subject. She and her mother-in-law who also resided in the home were later added to the report with the allegations of Burns and Scalding, LOMC, LOS, and IG . A subsequent report regarding the same incident was registered on the same day and that report named the provider's husband as the sole subject of the report. The next day, a neglect petition was filed and the newborn was paroled to her mother. However, after a few days the newborn was removed from her mother's care due to the mother's drug use. The allegation of Burns was substantiated against the provider and the mother-in-law, and the allegations of IG, LOMC LOS were unsubstantiated. The allegation of LOMC was substantiated against the provider's husband and the allegations of LOS, Burns, and IG were unsubstantiated. The allegation of IG was substantiated against the mother and the other allegations were unsubstantiated. In 2009 there was a request for a Fair Hearing to overturn the indication of the report; however, because the request was untimely, the determination remained unchanged.

The SCR report received on 6/11/08 alleged that the provider's husband was verbally abusive to their 12-year-old child, and had a history of being verbally and physically abusive to all their children. The report further alleged that the provider failed to protect the children. The report also alleged that the father often drank to the point of intoxication in the presence of the children and that about 18 months prior he drove while intoxicated and the 12-year-old was a passenger in the car.

ACS convened a Child Safety Conference on 6/12/08 which was attended by family members, including the 12-year-old child. Following the conference, the child refused to return home, insisting that he was fearful of his father. The 12-year-old child (the only minor child at the conference) was removed from his parents and on 6/13/08; an Article 10 Petition of Neglect was filed against the parents on behalf of the minor children. The 12-year-old child was then returned to the parents and the court ordered ACS supervision of all the minor children in the home. The court ordered the father to enter an alcohol treatment program; no services were ordered by the court for the mother. The father began services on 6/18/08.The allegations of PD/AM and IG were unsubstantiated against the provider and the same allegations were substantiated against the father.

On 12/23/08 the neglect case was Adjourned in Contemplation of Dismissal (ACD) for 6 months. The ACD expired on 6/2/09; the case was closed.

Known CPS History Outside of NYS

There was no known CPS 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

There is no record of Preventive Services 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.

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the provider comply with discipline standards?	☐	☒	☐	☐
Was a Criminal History check conducted? Date:	☐	☒	☐	☐
Was a check completed through the State Central Register? Date:	☐	☒	☐	☐
Was a check completed through the Staff Exclusion List? Date:	☐	☒	☐	☐

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