Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-21-009

Prepared by: New York State Office of Children & Family Services

Issue Date: Aug 10, 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
Age: 5 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 02/10/2021
Initial Date OCFS Notified: 02/10/2021

Presenting Information

An SCR report alleged that on 2/8/21, the 5-month-old infant became unresponsive while in the care of the daycare provider. The daycare provider put the child down for a nap around 12:30 PM. Just before 3:30 PM, she found him not breathing; he was blue-faced, had blood in his nose and a blanket over his face. On that day, he was transported and admitted to a hospital. On 2/10/21, the infant passed away due to cardiac criteria and multiple organ failure as a result of the events of 2/8/21. The day care provider could not provide an explanation for the infant's death, and prior to 2/8/21, he was otherwise healthy. The infant's condition was consistent with smothering, though no official cause of death had yet been established. The parents had no role.

Executive Summary

On 2/10/21, the Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report regarding the death of the 5-month-old male infant that occurred on that date. OCDCFS had an open CPS investigation at the time, which was received on 2/8/21, following the infant being found unresponsive by the daycare provider. Residing in the daycare provider's home was the daycare provider, her husband and their 9-year-old child. The infant resided with his parents and the parents had no other children.

OCDCFS conducted a joint investigation with law enforcement and it was learned that the 5-month-old infant’s father dropped him off at a licensed home daycare at 7:00 AM on 2/8/21. On that date, the daycare provider was caring for the infant, four other daycare children, and her own 9-year-old child. Around 12:30 PM, the daycare provider placed the infant on his back to sleep on an adult bed upstairs. There was a comforter, pillows, and blankets on the bed and the infant was covered with the comforter. The daycare provider reported that she checked on the infant about every 30 minutes.

Around 3:00 PM, the daycare provider asked her 9-year-old child and an 8-year-old daycare child to go and get the infant up from his nap. When the children entered the bedroom, they saw that the infant was unresponsive and there was a blanket covering his head so they alerted the daycare provider. The daycare provider brought the infant downstairs and she called 911 and performed CPR on the infant. She asked the 8 and 9-year-old children to go across the street to the infant’s home and get the infant’s father. EMS arrived and they performed life-saving measures in the ambulance while in route to the hospital. Upon arrival to the hospital, the infant regained a pulse and he was placed on life support. The infant was taken off life support and pronounced dead at 2:03 PM on 2/10/21.

An autopsy was performed, and the cause of death was unexplained sudden death of infant (intrinsic and extrinsic factors identified) and the manner of death was undetermined. The autopsy report stated that “after a comprehensive investigation and studies including autopsy, toxicology, microbiology, histology, radiology, and molecular studies, no definitive cause of death was found.” The respiratory viral panel was positive for rhinovirus/enterovirus and this could not be completely ruled out as a contributary factor in this case. The report additionally stated that the infant “was placed down to sleep in an adult bed surrounded by soft bedding material and reportedly found completely covered by the blanket per other children at the scene. The position of the infant’s face/head in relation to the blanket could not be confirmed by any adults or investigators as the blanket had been moved by the other children. This raises the possibility of asphyxia as a cause of death, however, it cannot be definitively proven based on the autopsy findings and the available investigation information.”

Law enforcement closed their investigation with no charges filed. The investigation resulted in several daycare violations

including lack of supervision, unsafe sleep practices, failing to remain on the same floor as children in care and using unapproved space (second floor) for childcare. As a result of the violations, the daycare license was suspended on 2/12/21 and the daycare closed on that date. The daycare provider decided not to have a hearing to re-open her daycare and she surrendered her license on 4/19/21.

Based on information gathered, OCDCFS determined there was credible evidence to substantiate the allegations of DOA/Fatality and Inadequate Guardianship against the daycare provider. The daycare provider and the infant's parents were referred for bereavement services and they declined.

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:
Safety Assessments were not required to be completed since this was a daycare case. The allegations were substantiated based on evidence gathered and the case was closed.

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:
Casework activity was commensurate with best casework practice.

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: 02/10/2021 **Time of Death:** 02:03 PM

Date of fatal incident, if different than date of death: 02/08/2021
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Onondaga
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? No - but needed
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: NYS Daycare Licensing
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	Male	5 Month(s)
Deceased Child's Household	Father	No Role	Male	30 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	54 Year(s)

LDSS Response

OCDCFS completed all CPS investigative requirements. They searched SCR history, notified the DA's office of the infant's death, and they spoke to the source of the report, the medical examiner, daycare licensing staff, and law enforcement. OCDCFS interviewed the daycare provider, her husband and their 9-year-old child, the 8-year-old daycare child, the parents of the infant, and the parents of the four additional daycare children. Home visits were conducted at the infant's home and at the daycare provider's home. The infant's pediatrician records and the mother's prenatal records were reviewed and there were no concerns noted.

During interviews with the daycare provider, she reported that the infant seemed to be in good health when he arrived at

her home at 7:00 AM. She said her 9-year-old child slept in her bedroom upstairs, so the child's twin-sized bed was pushed up against a queen-sized bed. The day care children napped from approximately 1-3 PM every afternoon. On 2/8/21 around 12:30 PM, she began putting the daycare children down for a nap. She placed the infant on the crack between the two beds and she pulled a comforter up from the bottom of the bed and covered him up to his stomach. She propped a pillow on his right side and folded the comforter on his left side to keep him from rolling off the bed. She checked on him about every 30 minutes and each time he was still sleeping on his back. Around 3:00 PM, she asked the 8 and 9-year-old children to get the infant up from his nap while she was getting the other children up. She heard the children yell for her so she went upstairs and saw that the infant was very pale. She told the children to get the infant's father and she brought the infant downstairs. She called 911 and performed CPR until EMS arrived and took over.

The daycare provider's husband stated that he was at work when he received a call from his wife at 4:27 PM telling him that the infant would not wake up and she thought he died.

The infant's parents reported that the infant was healthy, and he was developmentally on target. He had been going to the licensed daycare home across the street since he was six weeks old. The parents had known the daycare provider for three years and they had no previous concerns for the provider's care of the infant. The father said he dropped the infant off at daycare on 2/8/21 at 7:00 AM and the infant seemed to be fine at that time. Around 3:00 PM, the father was home when the daycare provider's 9-year-old child knocked on his door and told him to come to the daycare. When the father entered the daycare, he saw that the daycare provider was on the phone with the 911 dispatcher and she was performing CPR on the infant, who was blue in color.

The daycare provider's 9-year-old child was assessed to be safe in her parents' care. The 9-year-old child and the 8-year-old daycare child were interviewed together. They reported that the infant was sleeping on the daycare provider's bed and the daycare provider asked them to go and wake the infant up from his nap. When they entered the bedroom there was a blanket covering the infant's head. They said the provider covered the infant's head with a blanket when he napped because it helped him go to sleep. The infant wouldn't wake up and he made a gurgling noise when they tried to move him. They yelled for the provider, who came into the bedroom and started performing CPR. She told them to go and get the infant's father so they ran to the infant's home. They said law enforcement was arriving when they got back and they watched the younger children until their parents picked them up.

The parents of the daycare children reported they never had any concerns for the daycare provider caring for their children. The daycare children were assessed to be safe in their parents' care.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a 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)?Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

057648 - Deceased Child, Male, 5 Mons	057651 - Day Care Provider, Female, 54 Year(s)	DOA / Fatality	Substantiated
057648 - Deceased Child, Male, 5 Mons	057651 - Day Care Provider, Female, 54 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐

Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The infant's parents and daycare provider were provided with information on bereavement services and they declined.

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 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

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

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

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:	☐	☐	☐	☒

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