Report Identification Number: SV-23-063

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

Issue Date: May 16, 2024

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: Westchester
Date of Death: 12/11/2023
Age: 3 month(s)
Gender: Female
Initial Date OCFS Notified: 12/14/2023

Presenting Information

On December 14, 2023, the death of the 3-month-old subject child was reported to OCFS by the Westchester County Department of Social Services (WCDSS) through the required 7065 Agency Reporting Form. The child was listed on an open daycare investigation which began on December 7, 2023.

Executive Summary

This fatality report concerns the death of a 3-month-old female child, which occurred on December 11, 2023. On December 7, 2023, the Westchester County Department of Social Services (WCDSS) received an SCR daycare investigation regarding the subject child. The SCR report contained allegations of Inadequate Guardianship and Lack of Supervision against three daycare providers, other adult 1 (OA1), other adult 2 (OA2) and other adult 3 (OA3). The allegations against the other adults were pertaining to the subject child. In addition, a duplicate report was received on December 7, 2023, and an additional info was received on December 12, 2023. At the time of the subject child's death, she resided with her mother, father and 3-year-old surviving sibling.

On December 7, 2023, the subject child was dropped off at her daycare at approximately 8:35AM by her mother. At drop off, the child appeared normal and shortly after drop off, she was fed. The subject child was then put down for a nap; she was swaddled and placed in a Pack 'N Play. At approximately 10:00AM, daycare staff went to wake the subject child and when doing so, observed her eyes to look purplish. The daycare staff acted immediately and initiated CPR and contacted emergency medical services. The subject child began breathing and vomited two times. Emergency medical services arrived shortly after and took over life-saving efforts. The subject child was transported to the hospital where hospital staff determined she needed to be transported to a different hospital. The subject child remained hospitalized until her death on December 11, 2023.

WCDSS communicated with hospital staff and learned the subject child presented with little cerebral activity and was intubated and unresponsive. On December 11, 2023, the parents decided to proceed with withdrawing the child from life support and had chosen to donate her organs.

WCDSS worked in conjunction with law enforcement and communicated with the district attorney. At the time this report was written, there were no criminal charges pending against the daycare staff and it appeared the criminal investigation was on-going. In addition, WCDSS communicated with OCFS daycare licensing and worked in combination with them regarding their investigation. At the time of case closure, the daycare had received several violations, which were not noted to be related to the death.

WCDSS spoke with the medical examiner and learned an autopsy was performed. The medical examiner explained a possible cause of death; however, at the time this report was written, the autopsy report had not been received. The child tested positive for two respiratory infections at the first hospital; however, tested negative for one of the infections at the second hospital and in tests performed by the medical examiner. The medical examiner explained they reviewed law enforcement records and concluded that there could have been environmental factors such as the room temperature that may have contributed to the child's death. It was reported the room where the subject child was sleeping was very hot and that she was swaddled.

Following the fatality, WCDSS attempted to offer the family services via phone and through face-to-face contact;

however, the parents did not respond. WCDSS spoke with numerous collaterals during their investigation which included, law enforcement, hospital staff, the mother and father, grandparents, daycare staff, OCFS daycare licensing, and several parents whose children attended the same daycare.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
It was determined the child's death was not a result of abuse or maltreatment; therefore, there was no SCR report regarding the fatality.

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:
WCDSS investigated the circumstances surrounding the death and determined an SCR report was not necessary as there was no suspicion of abuse or neglect. The decision to close the daycare investigation 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: 12/11/2023 **Time of Death:** 04:46 PM

Date of fatal incident, if different than date of death: 12/07/2023
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Westchester

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 and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] 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	No Role	Female	3 Month(s)
Deceased Child's Household	Father	No Role	Male	37 Year(s)
Deceased Child's Household	Mother	No Role	Female	34 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Day Care Provider	No Role	Female	33 Year(s)
Other Household 1	Day Care Provider	No Role	Female	38 Year(s)
Other Household 1	Day Care Provider	No Role	Female	30 Year(s)

LDSS Response

On December 14, 2023, the death of the 3-month-old subject child was reported to OCFS by the Westchester County Department of Social Services through the required 7065 Agency Reporting Form. The child was listed on an open daycare investigation which initiated on December 7, 2023. The child was hospitalized after an incident at the daycare on December 7, 2023, until her death on December 11, 2023.

On December 7, 2023, WCDSS interviewed the mother and father at the hospital. During their interviews, the mother explained she dropped the SC off at her daycare between 8:30-8:40AM. The mother reported at approximately 10:12AM, the staff attempted to contact her, and she was told that OA3 was at the hospital with the child. The mother reported the daycare staff informed her the child was fed bananas, milk and then the SC was put down for a nap. The mother reported at 9:55AM the SC was found with blue around her eyes and observed to have shallow breathing. The daycare staff attempted CPR and the SC threw up. Emergency services were contacted and continued CPR and transported the SC to the hospital. WCDSS inquired if the child had any medical complications or was displaying signs of being ill. The mother reported the SC was showing common cold symptoms during the week, such as a runny nose, cough, and a fever for only one day. The parents reported the child was seen at the pediatrician the week prior to the incident and the pediatrician did not have concerns for the SC. The child received immunizations at that visit. Both parents denied having concerns for the daycare or the staff. WCDSS obtained the whereabouts of the 3yo SS and assessed him to be safe in the care of his paternal grandfather.

On December 8, 2023, WCDSS and OCFS daycare licensing met with and interviewed all three daycare providers OA1,

OA2 and OA3. During their interviews, OA1 explained the mother arrived at the daycare at 8:35AM and dropped off the SC who she observed to look “normal”. OA1 reported at 8:50AM, she fed the SC a jar of banana baby food but reported the SC ate very little. Around 9:00AM, OA1 prepared 4oz of formula which the SC finished. The OA1 then proceeded to put the child down for a nap. The SC was put into a sleep sack and laid on her back in a Pack 'N Play, and she fell asleep around 9:20AM. The OA1 denied any objects being in the Pack 'N Play and denied the SC used a pacifier. Around 9:35AM, the OA1 checked on the SC and other children sleeping in the room and there were no concerns. At 9:45AM, OA2 reported entering the room to check on the children and there were no concerns. At 10:00AM, OA2 entered the room, picked up the SC and observed the area under the SC eyes to look “purplish”. The OA2 told OA1 about the SC’s appearance and the OA1 immediately began CPR. The OA1 reported once she started CPR the SC vomited, she then took the SC to the kitchen and laid her on her back and the SC began breathing and vomited again. EMS arrived right after the SC vomited for the second time, they took over life-saving efforts and transported the SC to the hospital. The OA3 was questioned as to her whereabouts during the incident, she explained she was not at the daycare at the time of the incident and had left at 9:55AM for a conference. The OA3 was notified by her staff and returned to the daycare while EMS was still there. The OA3 reported that she left with the SC to be transported to the hospital.

WCDSS spoke with several parents whose children attended the daycare. All parents had positive remarks for the daycare and staff, and everyone denied having any concerns.

WCDSS investigated the circumstances surrounding the death and determined an SCR report was not necessary as there was no suspicion of abuse or neglect. The decision to close the daycare investigation was appropriate and the investigation was closed on February 2, 2024.

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 referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Westchester County Department of Social Services referred this case to their OCFS approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☐	☐	☒	☐
At 30 days?	☐	☐	☒	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Explain:
There was no SCR report regarding the death; therefore, the completion of safety assessment tools was not required.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☒	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
WCDSS made diligent efforts to contact the mother and father to provide bereavement services; however, the family did not respond.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☐	☒	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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:
WCDSS made diligent efforts to offer the mother and father bereavement resources and information for community agency referrals; however, the parents did not respond to requests for contact.

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? No
Explain:
WCDSS made diligent efforts to communicate with the parents regrading services they would like to offer; however, the parents did not respond to their efforts.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
WCDSS made diligent efforts to communicate with the parents regrading services they would like to offer; however, the parents did not respond to their efforts.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/07/2023	Deceased Child, Female, 3 Months	Day Care Provider, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 3 Months	Day Care Provider, Female, 38 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Female, 3 Months	Day Care Provider, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 3 Months	Day Care Provider, Female, 33 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Female, 3	Day Care Provider, Female,	Inadequate	Unsubstantiated	

Months	30 Years	Guardianship	
Deceased Child, Female, 3 Months	Day Care Provider, Female, 30 Years	Lack of Supervision	Unsubstantiated

Report Summary:
On December 7, 2023, the 3-month-old was attending day care. While at the day care, the childcare workers put the child down for a nap in a Pack 'N Play. The workers then left the room for approximately five to ten minutes, leaving the child unsupervised. While the child was in her Pack 'N Play, she stopped breathing and her lips turned blue. The workers returned to the room and one of the workers performed CPR on the child. The child then threw up and her color returned. There was no explanation as to what caused the child to go into distress. Since the child was in the care of the workers at that time, they were the alleged subjects.

Report Determination: Unfounded | **Date of Determination:** 02/02/2024

Basis for Determination:
WCDSS did not find a preponderance of evidence to substantiate the allegations against OA1, OA2 and OA3. WCDSS found that the daycare staff provided appropriate care to the SC when she was in medical distress. They found no evidence to support that the SC's medical emergency was due to negligence or abuse by the staff. The parents of the SC and other children that attended the daycare reported no concerns for the facility or staff members care of their children.

OCFS Review Results:
WCDSS immediately initiated their investigation, contacted the sources of the reports and searched Connections database for any CPS history. WCDSS worked in conjunction with local law enforcement and OCFS daycare licensing. WCDSS completed interviews with the daycare owner, staff and observed of the daycare. The mother and father of the subject child were interviewed, and the surviving sibling was assessed. WCDSS communicated with sufficient collaterals and had numerous supervisory consultations throughout the investigation. Notice of existence letters were provided to all the adults listed on the case.

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

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.

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