Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-24-016

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

Issue Date: Jul 18, 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
Age: 2 month(s)
Jurisdiction: Orange
Gender: Male
Date of Death: 03/02/2024
Initial Date OCFS Notified: 03/04/2024

Presenting Information

An SCR report alleged that on 02/22/24, the parents left the 2-month-old child in the care of a daycare provider. The daycare provider put the child in a crib at her home. Approximately 15 minutes later, the daycare provider went to check on the child and found him to be unresponsive, not breathing, and blue. She called 911. EMS responded and performed CPR while transporting the child to the hospital. The child was transferred to a second hospital where he was placed on a ventilator. On 02/26/24, the child was deemed brain-dead. On 03/02/24, the child was pronounced deceased. The child was otherwise healthy, and the daycare provider did not provide an explanation for the death.

Executive Summary

This fatality report concerns the death of the 2-month-old child that occurred on 03/02/24. A report was made to the SCR on the same day, alleging the daycare provider was caring for the child at the time the child was found unresponsive. The child was placed on life-support until he was pronounced deceased on 03/02/24. A report regarding the fatal incident was made to the SCR on 02/26/24 when the child was found unresponsive, and the daycare provider did not provide an explanation for the death. The daycare provider had cared for the child twice prior to his death. At the time of his death, the child resided with his parents. There were no other siblings in the home; however, there were siblings who resided outside of the country. It remained unknown if the siblings had a relationship with the parents or child.

Orange County Department of Social Services (OCDSS) coordinated investigative efforts with law enforcement upon the receipt of the SCR report regarding the fatal incident. The record reflected the criminal investigation was closed without charges filed. An autopsy was performed, and the cause of death was “asphyxia of a 2-month-old infant due to unsafe sleeping put in prone position in pack and play in child day care center.” The manner of death was an accident.

The parents were interviewed, and the mother stated that the daycare provider was caring for the child on the day of the fatal incident. When the parents returned to the daycare provider’s home to pick the child up, they were told the child was not doing well. The daycare provider’s adult daughter contacted emergency services, who responded to the home and transported the child to the hospital where he was placed on life-support until it was withdrawn, and the child was pronounced deceased on 03/02/24.

The daycare provider reported caring for the child on two prior occasions. She reported placing the child face-down to sleep, and when the parents arrived to pick the child up, although he was breathing, his nose was bleeding and emergency services were called. The daycare provider reported she was told the child was younger than he was, and she did not know the child had congestion the day prior to the fatal incident.

OCDSS gathered collateral information from other parents who also utilized the daycare provider. There were no concerns for the care she provided to their children. The maternal aunt reported telling the daycare provider that the child was 3 months old. The reason for this remained unknown.

OCDSS substantiated the allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the daycare provider. The Investigation Conclusion Narrative stated the daycare provider was unaware of safe sleeping recommendations. She placed the child to sleep on his stomach with his head turned to the side, putting him at risk of harm. The autopsy report reflected the child died as a result of the unsafe sleeping environment. The record reflected the daycare provider was not licensed to operate the daycare and OCFS issued a cease-and-desist letter regarding the daycare

provider's ongoing care of children in her home.

OCDSS completed required reports timely and accurately. Casework activity reflected that of best casework practice and the case was closed on 05/03/24.

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 as the investigation was appropriately coded as a daycare investigation. The decision to close the case was appropriate.

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 notes a consultation took place, but no details noted.

Explain:
Casework activity was commensurate with case circumstances.

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: 03/02/2024 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 02/22/2024

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 05:32 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Total number of deaths at incident event:
Children ages 0-18: 0
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	No Role	Male	53 Year(s)
Deceased Child's Household	Mother	No Role	Female	42 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	46 Year(s)

LDSS Response

On 03/02/24, OCDSS received the fatality report from the SCR. At the time of the death, there was an open CPS investigation that began on 02/26/24, regarding the fatal incident. There were concerns that the daycare provider placed the child face-down to sleep and the child was later found unresponsive, resulting in his hospitalization. The child was on life-support throughout his hospitalization and was pronounced deceased after life-support was withdrawn. The children who attended the daycare were assessed to be safe with their caregivers.

The record reflected the parents left the child in the care of the daycare provider on 02/22/24. A law enforcement officer reported that the parents went to the daycare provider's home approximately 45 minutes after the child was placed to sleep. At that time, the child was in distress and emergency services were called. Law enforcement officers responded to the home, performed CPR, and transported the child to the hospital. The child was intubated and had limited brain activity.

On 02/27/24, OCDSS interviewed the daycare provider. She reported that the parents dropped the child off on 02/22/24 around 6:30 AM. The daycare provider fed the child throughout the day and at around 5:00 PM, she placed the child face-down to sleep with his face turned to the left. When the parents arrived to pick up the child, the daycare provider asked her adult daughter to get the child from the Pack 'N Play. The adult daughter found the child in the same position he was placed to sleep in and noticed "something isn't right." The daughter yelled to the daycare provider that something was wrong and called 911. First responders arrived and transported the child to the hospital. The daycare provider reported the parents told her that the child was taken to the doctor the day prior for congestion; however, she was not privy to the information prior to the fatal incident.

After receiving the fatality report on 03/02/24, OCDSS immediately contacted the medical examiner, source of the report and documented a CPS history check.

On 03/12/24, OCDSS observed law enforcement interview the parents. The mother stated the child was dropped off at the daycare provider's home around 6:30 AM on the day of the fatal incident and stated the daycare provider was aware the child had a "slight cold". Around 5:30 PM on 02/24/24, the parents went to pick up the child and were told the child was not doing well. The parents' recollections of the fatal incident were consistent with what the daycare provider reported.

OCDSS contacted collaterals who utilized the daycare provider for their children. The daycare provider was described as a "Godsend" and there were no concerns for her care of children.

OCDSS determined and closed the investigation after gathering enough information to determine the allegations. The parents were offered bereavement services; however, it remained unknown if they utilized them.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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 referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The death was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
067768 - Deceased Child, Male, 2 Month(s)	067771 - Day Care Provider, Female, 46 Year(s)	DOA / Fatality	Substantiated
067768 - Deceased Child, Male, 2 Month(s)	067771 - Day Care Provider, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
067768 - Deceased Child, Male, 2 Month(s)	067771 - Day Care Provider, Female, 46 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?	☒	☐	☐	☐
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 at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The family was offered bereavement services. It remained unknown if they utilized the service referral.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The parents were referred to bereavement services. It remained unknown if they utilized the services.

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? No

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

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.

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