Child Fatality Report

Report Identification Number: SV-17-052

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

Issue Date: Apr 30, 2018

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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 11/14/2017
Initial Date OCFS Notified: 11/14/2017

Presenting Information

An SCR report was received which alleged on 11/14/17, the day care provider laid the 1-year-old child down for a nap and did not check on the child for an extended period of time. At approximately 3 PM, the day care provider found the child on her side, unresponsive and with a blanket in her mouth. The child's mouth smelled and tasted like vomit. The day care provider called 911, and the child was transported to the hospital. She was pronounced deceased at 3:18 PM. The child was otherwise healthy and had no visible injuries. There was no plausible explanation to her death.

Executive Summary

This fatality report concerns the death of a 1-year-old child (SC) that occurred on 11/14/17 while the child was in the care of a day care provider (DCP). A report was made to the SCR on this same date, with allegations of IG and DOA/Fatality against the day care provider. Suffolk County Department of Social Services (SCDSS) received the report and conducted a thorough investigation into the child's death. At the time of this writing, the final autopsy report was not available, and the cause and manner of death had not yet been determined.

The child resided with her mother, father, and 3-year-old brother at the time of her death. She was considered a healthy child with no underlying medical concerns; however, she was suffering from a mild cold and teething within the days leading up to her death. It was discovered the parents had been utilizing the same day care provider for both of their children over the course of the past three years: the 3-year-old had attended four days a week until he began pre-school, and the 1-year-old attended four days a week since January 2017. The day care provider ran her day care services from her own home, and was responsible for the 1-year-old child as well as two other unrelated children.

On the morning of 11/14/17, the now deceased child was dropped off at the day care at 8:30AM; the two other unrelated children were also at day care that day. The provider was aware the child had been ill and teething, and gave her a small dose of Ibuprofen shortly after her arrival to the home. The provider then placed the child down for a nap in a "Pack 'n Play" in an upstairs bedroom. The day care provider shut the bedroom door, and did not check on the child again until approximately five hours later. At that time, the child was found to be unresponsive, lying on her side with her face pressed into a baby blanket and the side of the "Pack 'n Play." The day care provider called 911, and law enforcement arrived at the scene. The child was taken to a nearby hospital and pronounced deceased at 3:18PM.

Prior to this incident, the parents of the child had no concerns regarding the day care provider. From the time the investigation began to the time of this writing, SCDSS met with and interviewed the child's parents, assessed the safety of her sibling as well as the safety of the unrelated children, and observed home environments, finding no concerns. Further, SCDSS spoke with several collateral sources and referred all individuals to appropriate services in response to the fatality. There were no criminal charges pursued against the day care provider. During the investigation, SCDSS worked collaboratively with OCFS. OCFS determined that the day care provider had been running an unlicensed daycare from her home. The day care provider was in violation of regulation, as she was caring for more than two children for more than three hours a day at one time, several days per week. OCFS issued the day care provider citations as well a cease and desist order, and she was no longer allowed to provide day care services until further action. SCDSS found no evidence to support the allegations in the report, and therefore unfounded and closed the case.

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:
By the close of the investigation, SCDSS gathered sufficient information to appropriately assess the safety of the SS, as well as make a determination.

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:
The level of casework activity was commensurate with the case circumstances. There were several progress notes which provided details of supervisory consults between supervisors and caseworkers. SCDSS' decision to close the case 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: 11/14/2017 **Time of Death:** 03:18 PM

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

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 03:00 PM
Did EMS 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? 5 Hours
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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Father	No Role	Male	36 Year(s)
Deceased Child's Household	Mother	No Role	Female	38 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	58 Year(s)

LDSS Response

On 11/14/17, SCDSS received a report regarding the death of SC while in the care of DCP. SCDSS initiated their investigation within 24 hours and coordinated their efforts with LE and OCFS. SCDSS completed a CPS history check regarding the DCP, gathered information surrounding the SC and her family, and promptly notified the DA and ME of the fatality.

Through interviews and collateral sources, SCDSS learned DCP had been babysitting SC out of her home 4 days a week since January 2017. Prior to this, DCP babysat SC's SS 4 days a week for approximately 3 years, until the SS began attending pre-school. DCP was also responsible for watching and caring for 2 other unrelated CHN in her home at the time she was caring for SC.

On 11/15/17, SCDSS completed a visit to SC's home, spoke at length with PGM, and assessed the SS and environment; no concerns were noted and appropriate provisions were observed. On this same date, SCDSS assessed the physical environment of DCP's home and noted appropriate sleeping provisions throughout the house and no safety concerns or hazards.

Through interviews with SC's parents, it was discovered SC had a cold for one week prior to her death. BM reported SC had a runny nose and slight cough, but no fever. The parents did not feel the child was ill enough to need medical attention. They also explained SC was teething, and had just "cut molars" a day or two before she died. It was determined SC never slept for long periods, and it was rare if she napped for 2 or more hours at once; DCP was aware of this. On the

morning of 11/14/17, the parents stated SC was fed and then dropped off to DCP at 8:30AM. BM stated SC appeared fine. BM and BF reported the next they heard from DCP was when she called to tell them to go to the hospital because SC was found not breathing.

SCDSS interviewed DCP surrounding the incident. DCP reported she was aware SC was ill and teething the week prior to her death. She stated SC arrived at her home the morning of 11/14/17, and appeared "pale and cranky." DCP stated at 9:15AM she gave SC a small amount of children's Ibuprofen according to product instructions, which the parents approved of DCP administering on an as-needed basis. DCP explained she brought SC upstairs at 10:15AM and placed her in a "Pack 'n Play" to nap; she was aware SC did not usually nap longer than 1 to 2 hours at a time. DCP stated she closed the door and went back downstairs; she did not own a baby monitor. DCP did not hear SC stirring, so she allowed her to sleep as long as she wanted. DCP did not check on SC again until approximately 3PM. When DCP entered the room, she found SC on her side with her face pressed into a baby blanket, which was pushed up against the mesh of the "Pack 'n Play." DCP said SC's lips were blue and she was cold to the touch. DCP called 911 and began CPR until LE arrived. SC was then transported to the hospital, where she was pronounced deceased.

DCP and the parents' accounts of what occurred on the date of SC's death were consistent with what they told LE and the ME. Throughout the investigation, SCDSS contacted collateral sources and appropriate services were offered to the family and DCP. At the time of this writing, the official cause and manner of death were not yet released; however, the ME informed SCDSS there was no evidence of any trauma or abnormalities that may have caused SC's death, and therefore the death was being considered Sudden Unexplained Infant Death Syndrome.

Upon learning of the fatality, OCFS investigated the DCP. OCFS determined DCP was not licensed through NYS, and therefore was providing daycare services illegally from her home. As a result, DCP was issued citations as well as a cease and desist order. There were no criminal charges filed against the DCP. SCDSS did not find evidence to support the allegations in the report, and therefore unfounded and closed the case.

Official Manner and Cause of Death

Official Manner: Pending
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)?Yes
Comments: This fatality investigation was conducted by the Suffolk County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Suffolk County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045601 - Deceased Child, Female, 1 Yrs	045605 - Day Care Provider, Female, 58 Year(s)	Inadequate Guardianship	Unsubstantiated
045601 - Deceased Child, Female, 1 Yrs	045605 - Day Care Provider, Female, 58 Year(s)	DOA / Fatality	Unsubstantiated

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?	☒	☐	☐	☐

Additional information:

SCDSS spoke with all individuals named on the report as well as several collateral sources. Progress notes were entered timely. There were no required logs needing review.

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 safety 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?	☐	☐	☒	☐

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: A RAP was not required in this case.				

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: No children needed to be removed as a result of this fatality investigation or for reasons unrelated.				

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:
Bereavement services were offered to the family of the deceased child as well as the day care provider, but all declined.

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:
SCDSS offered the family service referrals for bereavement counseling in response to SC's death, but the parents and declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
SCDSS offered the parent, PGM, and DCP service referrals for bereavement counseling in response to SC's death, but all declined.

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? Yes

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 is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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:** 11/14/2017	☒	☐	☐	☐
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