Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-24-046

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

Issue Date: Jan 28, 2025

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: 7 month(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 10/01/2024
Initial Date OCFS Notified: 10/01/2024

Presenting Information

It was reported that on 10/1/24, at 12:30pm, the SC (7- months- old) was in the care of her Daycare Provider (DCP) at the DCP's home. The DCP placed the SC down on her back on a twin-size mattress for a nap. When the DCP checked on the SC, the SC was observed with her head wedged between the bed and a futon. The SC was not breathing and nonresponsive. The DCP started CPR on the SC and called 911. EMS also performed CPR on the SC and transported her to the hospital. Life saving measures were unable to revive the SC and she was pronounced dead on 10/1/24 at 2:36pm. The SM and SF knew that the DCP did not have proper provisions for the SC and that she was placing the SC on a mattress and not a proper sleeping area. The SM and SF chose to continue to leave the SC in the care of the DCP and did not provide the DCP with a pack-n-play, crib, or other appropriate alternate sleeping arrangement. The unsafe sleep arrangement contributed to the SC's death.

Executive Summary

This report concerns the death of the 7-month-old female subject child. Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the SC's death on 10/2/24. At the time of the SC's death, she resided with her mother and father. The SC was an only child. The SC was an otherwise healthy child at the time of her death.

On the day of 10/1/24, the Day Care Provider (DCP) placed the SC on her back, face up on the surface of a twin -size bed at 12:30PM for a nap. Initially, the DCP checked on the SC frequently as the SC did not go to sleep quickly. However, she could see the SC's face from the door and knew her eyes were open. The distance between the kitchen and bedroom was about five feet. The DCP remained in the kitchen eating her lunch. When she checked on the SC again, she noticed that she could no longer see the SC's face. The DCP walked to the foot of the bed and observed that the SC's head was stuck between the mattress and the back of a futon that was propped up against the bed. When the DCP attempted to move the SC, she knew something was wrong. She immediately picked the SC up and ran downstairs. She called 911 and attempted CPR. She denied hearing anything that would indicate the SC was in distress prior to her death. The DCP denied that she and the parents talked about safe sleep nor did the parents provide the DCP with an appropriate sleep plan for the SC while in her care. When asked why they didn't provide safe sleep for their child while at daycare, the parents advised that the SC was only in the daycare part-time, and the DCP had very limited space. They didn't want to trouble the DCP by providing a sleep apparatus for the SC as it would take up too much room. The SF and SM advised that the day of the incident started as any other day. They both took the SC to daycare. The parents advised the SC showed no signs of illness or distress when they left her with the DCP.

SCDSS made the appropriate determination to substantiate the allegations of Inadequate Guardianship against the mother and father regarding the death of their child. The parents failed to provide the DCP with a safe sleeping apparatus despite being aware that the SC was sleeping on a futon or bed regularly when in the care of the daycare provider. SCDSS made the appropriate determination to substantiate the allegations of Inadequate Guardianship and DOA/Fatality against the daycare provider. The DCP didn't display an adequate level of care for the SC by failing to secure a safe sleeping space with an age-appropriate sleeping apparatus that met the criteria for the child's developmental age. She routinely placed the infant on a futon or twin bed during her nap time which ultimately caused the SC's death.

OCFS served the DCP with a formal cease and desist letter. The DCP is no longer caring for children in her home.

EMS performed life saving measures on the SC at the scene to no avail. The SC was transported to the hospital where she was pronounced deceased on 10/01/24 at 2:36PM. The Suffolk County ME reported that based on scene reconstruction, it appeared as if the SC's head was wedged between mattress and the back of a futon, causing Asphyxiation. There were no signs of abuse or trauma. Toxicology was pending at the time of case closing. LE was notified of the fatality and began an investigation. At the time of closing, LE had not made an arrest. They deemed the SC's death as accidental as no criminal intent could be proven.

No drugs or drug paraphernalia was observed in either home. Safe sleep and infant supplies were observed in the family home.

The parents and the Daycare Provider were offered bereavement services. It is unknown if the parties engaged with services. The parents had strong family supports and the DCP relied heavily on her religion and her church community.

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?** Yes

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

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 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

Child Fatality Report

Incident Information

Date of Death: 10/01/2024 **Time of Death:** 02:36 PM

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 12:30 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	7 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	53 Year(s)

LDSS Response

On 10/02/24, SCDSS received a report regarding the death of the subject child which occurred on 10/1/24. SCDSS initiated their investigation into the fatality within 24 hours and coordinated efforts with law enforcement. SCDSS contacted the source of the report, completed a CPS history check which revealed no prior child welfare history, and informed the DA of the fatality. There were no surviving siblings.

SCDSS collaborated with law enforcement agencies to conduct an interview with the parents on 10/2/24 at the family residence. The SM and SF reported on the day of the incident, the SC was acting normal when they left her with the DCP. The parents were aware that the SC slept on a bed or in her car seat at naptime. They denied that they discussed safe sleep with the DCP, nor did they provide the DCP with an appropriate sleeping apparatus as the SC only attended part-time and space was limited. The DCP babysat for about 8-10 children and the space was cramped. The SM found out about the incident after her work shift as she is unable to answer her phone while working. The SF stated he received a call alerting him to get the hospital as soon as possible as his infant daughter was not doing well and that police and EMS were

working to resuscitate her.

SCDSS collaborated with law enforcement agencies to conduct an interview with the Daycare Provider (DCP) at her residence on 10/2/24. She confirmed she cared for five children in her home. She has been a daycare provider informally for twenty years; nothing like this had ever happened before. She stated that on 10/1/24, the day started as usual with the SC being dropped off at about 7AM by both of her parents. It was a normal day with the children playing. She gave the SC a bottle between 11:30AM-12PM. She immediately burped her and around 12:30PM, she put the SC on her back, on top of her blanket on her adult son's twin bed located in her bedroom. There is a futon that rests against the twin bed. She showed the SCDSS caseworker pillows that she propped against the wall and window as there is gap between them, and she didn't want the SC to fall between it. She denied she was ever presented with a safe sleep alternative from the parents despite them being aware that the SC was sleeping on a bed. When she put the SC on the bed, she was still awake. She went to the kitchen to eat her lunch while watching the other children play. She frequently walked the distance, five steps between the kitchen and the bedroom to check on the SC. Eventually the SC went to sleep. When she got up to check the SC again, she noticed that the SC had moved. She walked to the foot of the bed and observed that the SC head was stuck between the back of the futon and the mattress. When she tried to move her, she knew something was wrong. She immediately picked her up and ran downstairs, leaving the other children upstairs. She called 911 and attempted CPR. She denied hearing anything that would indicate the SC was in distress prior to her death. She stated EMS and LE arrived and took over care of the SC. The DCP has an adult child. OCFS advised the DCP that she was operating an illegal daycare and served her with a formal cease and desist latter.

EMS records reported that the SC was unresponsive. CPR was administered and life saving measures were performed to no avail. The SC was transported to the hospital where she was pronounced deceased on 10/01/24 at 2:36PM.

The SC's pediatrician reported no concerns. No drugs or drug paraphernalia was found in either home. The parents and DCP were provided with bereavement referrals and safe sleep was discussed with the parents.

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)?No

Was the fatality referred to an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069653 - Deceased Child, Female, 7 Month(s)	069655 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
069653 - Deceased Child, Female, 7 Month(s)	069655 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated

069653 - Deceased Child, Female, 7 Month(s)	069656 - Father, Male, 32 Year(s)	DOA / Fatality	Unsubstantiated
069653 - Deceased Child, Female, 7 Month(s)	069656 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
069653 - Deceased Child, Female, 7 Month(s)	069657 - Day Care Provider, Female, 53 Year(s)	DOA / Fatality	Substantiated
069653 - Deceased Child, Female, 7 Month(s)	069657 - 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☐	☐	☒
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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒

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 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