NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-14-022 **Prepared by: Rochester Regional Office**

Issue Date: 4/16/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 7 month(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 12/16/2014
Initial Date OCFS Notified: 12/16/2014

Presenting Information

On 12/15/14, the Monroe County Department of Human Services (MCDHS) received an SCR report which stated that the Day Care Provider (DCP) swaddled the SC and put him down in the bassinet. Between 3:30 and 4:00 pm, the SC was found face down and turning blue. The SC was rushed to the hospital and was in intensive care and may not survive due to lack of oxygen. Due to the severity of the situation and no plausible explanation, a report was registered. The DCP supervised at least four other toddlers plus a couple of her own biological children.

On 12/16/14, MCDHS received a subsequent SCR report which stated that on 12/15/14, the DCP put the SC down for a nap when he became fussy. When the DCP checked in on the SC at about 4:00pm, she found him face down and not breathing. The SC was brought to the hospital where he passed on 12/16/14. The SC was an otherwise healthy child with no known medical conditions.

Executive Summary

This fatality report concerns the death of a seven-month-old male that occurred on 12/16/14. The preliminary autopsy report received on 1/7/15 indicated the cause and manner of death were “pending further investigation”. MCDHS received an initial SCR report regarding the incident and a subsequent SCR report regarding the death.

On 12/15/14, the SC was at day care from 7-7:30am to 4-5:00pm. The mother told the DCP that he did not sleep well the night prior. The SC’s nose started to run and he had a cough for about a week. At 1:45-2:00pm, the DCP could not soothe the SC so she swaddled him in a twin sheet she folded in half. She placed him on his back in a rock and play with no blankets and did not buckle him in. The DCP checked on him every 15 minutes and he was always on his back. At about 3:15pm she woke the other DC children. She did not check on the SC again until 4:00pm and she found the SC swaddled but he was face down. He was limp, pale, and his lips and eye sockets blue. She screamed to her husband who started CPR while she called 911 at 3:59pm. EMS arrived and the DCP called the mother. EMS transported the SC to the hospital where he was pronounced dead on 12/16/14.

The rock and play manual, which the DCP was required to read, stated “DO NOT use this product when the infant begins to push up on hands knees, call pull up or sit unassisted” & “ALWAYS use the restraint system.” MCDHS found that swaddling was not recommended for children over two months old.

On 12/17/14, OCFS Division of Day Care Services (DDCS) suspended the DC and sought to revoke the DC’s registration. DDCS found the DCP violated several regulations which were placing the SC in unapproved areas in inappropriate sleeping environments without a monitor and not providing competent supervision.

MCDHS conducted an adequate assessment of immediate danger to all children named in the report within 24 hours, completed adequate safety and risk assessments, and service needs were adequately assessed and offered.

Both SCR reports were appropriately IND and Sub for IG since the DCP created a significant risk of harm as the SC was over the age appropriate for swaddling and he could roll over and the rock and play was not created for sleeping. The DOA/Fatality allegation was Unsub. There was no trauma found to the SC and the final autopsy was not

completed. MCDHS reported that if there were suspicious findings of abuse or neglect the ME would call in a report.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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.

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: 12/16/2014 **Time of Death:** 03:18 AM

Date of fatal incident, if different than date of death: 12/15/2014

County where fatality incident occurred: MONROE
Was 911 or local emergency number called? Yes
Time of Call: 03:59 PM
Did EMS to 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? 30 Minutes
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? Yes
Licensing/Registering Agency: Child Care Council
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Month(s)
Deceased Child's Household	Father	No Role	Male	36 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	27 Year(s)
Other Household 1	Other Adult	No Role	Male	29 Year(s)

LDSS Response

Upon receipt of the initial SCR report, MCDHS spoke with the Hospital Social Worker (SW) who reported that the SC was not responsive. There were no signs of trauma and had been unable to stabilize the SC. On 12/16/14, the SC died at the hospital.

The DCP reported that the mother told her that the SC rolled over at home to sleep on his stomach as this was his preferred position for sleeping. Typically the SC slept well but when he did not she would swaddle him. The only time he was fussy was when he was not feeling well. The DCP stated the mother was aware that she swaddled the SC but she was unsure if the father knew. She denied that there were any accidents or falls for the SC. The SC was wearing a long sleeve onesie and diaper when she swaddled him. She gave him a pacifier and he went to sleep. The DCP and her husband denied ever observing any marks or bruises on the SC and had no concerns about his care. The temperature in the home was set to 70 degrees. The DCP stated that the mother was aware of the sleeping arrangements and she had no concerns. However, MCDHS found that the mother did not approve of the sleeping arrangements.

The DCP's husband reported that he returned home between 3:45-4:00pm. His version of events was consistent with the DCP's when he became involved.

According to the DCP and her husband, the other DC children were in the living room and their parents were called to pick them up early.

The parents reported that they stopped swaddling the SC at three-months-old and informed the DCP but never specifically asked her to stop swaddling him. However, they assumed the DCP stopped as well. The SC was placed on his back to sleep but he would roll over onto his stomach. The DCP told the mother that she swaddled him because he was flapping his arms. The mother stated that he would flap his arms when he was tired and could not sleep. The DCP agreed to check on the SC every 15 minutes when he was napping. According to the mother, the DCP was transferring the SC from the rock and play to a pack 'n' play which should have happened on 12/2/15. This was due to the fact that he moved himself from his back to his side and bruised his face on the bars. On 12/12/14, the parents noticed that the SC started to get a cough, was sneezing, and had a running nose. The parents had no concerns about the DCP or her husband.

The DCP told LE that the SC did not like sleeping well and did not appear to like sleeping in the pack and play so she was transitioning him back to the rock and play. She further reported that she did not plan to transition him out of the rock and play until he was a year old which was not consistent to what she reported to MCDHS. All other information obtained from the DCP by LE was fairly consistent information to MCDHS. LE observed no signs of trauma to the SC. LE took the bassinet, pacifier and swaddle into evidence.

MCDHS spoke with the parents of the other DC children who reported no concerns about the DCP.

According to the pediatrician, she was not aware of any significant sleeping problems that the SC was having so there were no recommendations to the family. The pediatrician denied telling the family to swaddle the SC ad she does not recommend swaddling a child past two-months-old. The pediatrician had no concerns.

According to the ME, there was an abnormality found in his intestine which could be related to a disease but they would be doing further testing.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
014001 - Deceased Child, Male, 7 Mons	014005 - Day Care Provider, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
014001 - Deceased Child, Male, 7 Mons	014005 - Day Care Provider, Female, 27 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:

MCDHS learned the names and contact information for all of the children that attended the DC. MCDHS contacted each parent(s) who declined to have their children interviewed.

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	☒	☐	☐	☐

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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/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	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

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? N/A
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
☒ 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 within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS history for the family or the DCP more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the provider comply with discipline standards?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** 01/03/2014	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 01/15/2014	☒	☐	☐	☐
Was a check completed through the Staff Exclusion List? **Date:** 07/25/2014	☒	☐	☐	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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