Child Fatality Report

Report Identification Number: NY-23-022

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

Issue Date: Aug 03, 2023

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:** Kings **Date of Death:** 05/11/2022
Age: 6 month(s) **Gender:** Male **Initial Date OCFS Notified:** 02/15/2023

Presenting Information

An SCR report dated 2/15/23 alleged the 6-month-old infant died while in the mother's care. The infant's death was the result of unsafe sleeping arrangements. The details regarding the sleeping arrangements and overall living environment at the time of the infant's death were unknown. A second SCR report was received on 3/11/23, that alleged the 6-month-old infant was in the care of a babysitter on 5/11/22. The babysitter put the infant down for a nap on a bed. She laid the infant down on his stomach and then left the infant unsupervised in the room for an unknown length of time. The babysitter checked on the infant after an unknown length of time and the infant was not breathing. The babysitter delayed medical treatment by waiting 30 minutes to call emergency services. The infant was pronounced dead at the hospital. The combination of the unsafe sleeping arrangement, the inadequate supervision, and the lack of immediate medical attention contributed to the infant's death.

Executive Summary

On 2/15/23, an SCR report was received by the New York City Administration for Children's Services (ACS) regarding the death of the 6-month-old male infant that occurred on 5/11/22. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother. At the time of the infant's death, he resided with his mother. The father resided out of the country, and the mother and infant had not visited the father since the infant's birth. The mother and father had another child in February 2023. At the time of the newborn child's birth, the mother reported to hospital staff that the 6-month-old infant had died in 2022. The death of the infant was not reported to the SCR when it occurred.

A second SCR report was received on 3/11/23, that contained allegations of DOA/Fatality, Inadequate Guardianship, Lack of Supervision, and Lack of Medical Care against the infant's babysitter at the time of his death. It was not documented who resided in the babysitter's home at the time of the infant's death; however, at the time the SCR report was received, the babysitter resided with her husband and two adult children. The case record did not reflect that ACS made attempts to speak to the babysitter's husband or adult children. The babysitter was spoken to and she denied that she currently babysat or cared for any children.

ACS interviewed the mother and assessed the newborn child to be safe in her care. Through speaking to the mother and collateral resources, ACS learned that the mother dropped the infant off at the babysitter's home at 10:00 AM on 5/11/22. The babysitter later placed the infant on his stomach on an adult bed for a nap and covered the infant's back and legs with a blanket. Approximately an hour later, the babysitter found the infant unresponsive and she called 911 and the mother. The infant was transported to the hospital via ambulance, where efforts to resuscitate the infant were unsuccessful. The infant was pronounced deceased at 5:40 PM.

An autopsy was performed following the infant's death, and the medical examiner said the babysitter provided a reenactment of the incident. It was not documented if the final autopsy report was received by ACS; however, the medical examiner reported, "it was concluded that the cause of death was undetermined as the unexplained sudden cause of death could have been attributed to both intrinsic and extrinsic factors." The medical examiner said the intrinsic factor was the infant had Rhino Virus and the extrinsic factor was the unsafe sleep conditions. Law enforcement reported that they had already investigated the infant's death and closed their investigation with no charges filed.

ACS referred the newborn child for Early Intervention services and offered preventive services and additional bereavement services to the mother. The mother declined all services, as she had enrolled in an online support group after

the death of the infant, and she said she had family support.

ACS unsubstantiated the allegations against the mother since it was determined the infant was in the care of the babysitter at the time of his death and the mother had provided adequate care to the infant. ACS substantiated the allegations of Inadequate Guardianship and Lack of Supervision against the babysitter based on a fair preponderance of evidence that the babysitter placed the infant to sleep on his stomach on an adult bed and left the infant unsupervised for an hour before checking on him and finding him unresponsive. The allegations of DOA/Fatality and Lack of Medical Care were unsubstantiated against the babysitter, as there was a lack of evidence that the babysitter caused the infant's death or that the babysitter delayed obtaining emergency medical care for the infant. No service needs were identified for the babysitter and both CPS investigations were closed.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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

Explain:

ACS appropriately unfounded the SCR report against the mother and indicated the SCR report against the babysitter.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:

Casework activity was not commensurate in that ACS delayed in investigating the allegations against the babysitter.

Attempts to interview the babysitter's other household members, the other child the babysitter was caring for at the time of the incident, and any other individuals that witnessed the incident were not documented by ACS.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The babysitter's husband and 2 adult children resided in the alleged subject babysitter's home and they were not added to the case or interviewed by ACS.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/11/2022 **Time of Death:** 05:40 PM

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

County where fatality incident occurred: Kings
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? 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: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	6 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Father	No Role	Male	34 Year(s)
Other Household 2	Other Adult - Babysitter	Alleged Perpetrator	Female	49 Year(s)

LDSS Response

ACS spoke to the sources of the reports, hospital staff, law enforcement, the Department of Health, and neighbors. They visited at the mother's and babysitter's homes, interviewed the mother and babysitter, and observed the newborn child. They spoke to the father over the phone. ACS determined the parents and babysitter had no SCR history and that law enforcement found no criminality regarding the infant's death.

ACS interviewed the mother on 2/15/23, and she informed ACS that the infant's death occurred at the babysitter's home on 5/11/22, and the babysitter was running an illegal daycare out of her home. Supervisory directives were given on 2/16/23 and 2/22/23 to interview the babysitter and to contact the Department of Health regarding the alleged illegal daycare; however, the Department of Health was not contacted, and attempts to interview the babysitter were not made until the second SCR report was received on 3/11/23.

During interviews with ACS, the mother reported that she utilized the babysitter 3 to 4 days per week since the infant was 2 months old. The mother said she dropped the infant off at the babysitter's home on 5/11/22 at 10:00 AM. The babysitter later called her and told her the infant was not breathing. She said the babysitter may have overfed the infant, then he was placed to sleep on his stomach, and he may have choked. She said the babysitter told her she heard the infant cry, but she did not attend to him right away because she was with another child. The mother said the babysitter told her she delayed calling 911 for approximately 30 minutes since she first took the infant to an upstairs neighbor for assistance, called the mother, then called 911. The mother said the babysitter watched approximately 10 children and she found out after the infant's death that the babysitter was not licensed. She said the babysitter hid the other children she was babysitting on that date in a neighbor's home before first responders arrived. The mother said the medical examiner's report listed the infant's cause of death as improper sleeping position, and she was upset the babysitter was not criminally charged with the death.

The father said he had not yet met the infant since he resided out of the country, but he spoke to the mother daily on the phone. He said the infant passed away in the babysitter's care and he denied having any concerns for the mother's care of the deceased infant or the newborn sibling.

The babysitter denied that she ever had a daycare in her home or that she babysat more than 2 children at a time. She said she currently did not babysit any children. She denied that the infant had a medical condition or health concerns on 5/11/22. She said the mother fed the infant a bottle prior to dropping him off and she later fed the infant yogurt. She said she placed the infant on his stomach on her adult bed for a nap around 2:30 PM, and she covered his back and legs with a blanket. She said there were no pillows or other items on the bed. She later heard the infant cry, but she was attending to another child at that time. When she checked on the infant around 3:30 PM, he was not breathing. The babysitter did not report what position the infant was found in. The babysitter said she brought the infant to the upstairs neighbor, who called 911, while she called the mother. She later learned the infant died. Additional details about the incident or the other child present were not documented.

The Department of Health inspector reported there were no signs of a daycare at the babysitter's home and the babysitter and her adult daughter denied there ever was a daycare. The inspector said the babysitter's adult daughter said she was aware of the infant's death, but she was not present when the incident occurred. Pediatrician records showed the infant was last seen for a well child visit on 4/26/22. The infant was noted to be congested, but with no cough or other health concerns.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a 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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064259 - Deceased Child, Male, 6 Mons	064260 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
064259 - Deceased Child, Male, 6 Mons	064260 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
064259 - Deceased Child, Male, 6 Mons	064262 - Other Adult - Babysitter , Female, 49 Year(s)	DOA / Fatality	Unsubstantiated
064259 - Deceased Child, Male, 6 Mons	064262 - Other Adult - Babysitter , Female, 49 Year(s)	Lack of Medical Care	Unsubstantiated
064259 - Deceased Child, Male, 6 Mons	064262 - Other Adult - Babysitter , Female, 49 Year(s)	Inadequate Guardianship	Substantiated
064259 - Deceased Child, Male, 6 Mons	064262 - Other Adult - Babysitter , Female, 49 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?	☒	☐	☐	☐

Additional information:
The father was interviewed over the phone since he resided out of the country. Attempts to interview the babysitter's household members and any witnesses to the incident were not documented by ACS.

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?	☐	☐	☒	☐

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:
Risk was adequately assessed for the newborn child. Bereavement and preventive services were offered to the mother and she declined.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother enrolled in an online support group following the infant's death. ACS referred the mother for additional bereavement services and she declined.

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
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used prescription drugs
- ☐ Used marijuana
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ With fetal alcohol effects or syndrome
- ☐ Exhibiting withdrawal symptoms
- ☒ 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 was no known CPS history outside of New York State.

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