Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-060

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

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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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 06/10/2023
Initial Date OCFS Notified: 06/12/2023

Presenting Information

An SCR report alleged that on 6/9/23 sometime before 7:15 PM, the child rolled off of the bed he was sleeping on and landed in a garbage can. The grandmother found the child unresponsive and the child's babysitter called 911. Emergency medical services arrived and began cardiopulmonary resuscitation. Resuscitation efforts continued en route to the hospital. The child arrived at the emergency department in cardiac arrest and was placed on life support. The child sustained an anoxic brain injury from being deprived of oxygen and succumbed to cardiac arrest on 6/10/23. It was believed the unsafe sleep environment contributed to the child's death.

Executive Summary

This fatality report is regarding the death of a 5-month-old male child that occurred on 6/10/23. An SCR report was received on 6/12/23 and alleged DOA/Fatality and Inadequate Guardianship against the grandmother and the child's babysitter. The child resided with his mother and father. There were no siblings or surviving children.

The Administration For Children's Services (ACS) coordinated investigative efforts with law enforcement. It was learned on 6/9/23, the mother dropped the child off to the babysitter. The babysitter was a long-time friend of the family and resided in the grandmother's home with her adult daughter. Shortly after the mother left, the child fell asleep and the babysitter brought him from her living space upstairs to a downstairs guest bedroom. The child was placed on the bed with pillows surrounding him. The grandmother had company over and when they left at 4:00 PM, she began to check on the child periodically. When the grandmother last checked on the child he was not on the bed. The grandmother questioned the babysitter, who thought he was on the bed where she had last left him. When the grandmother searched the room, she found the child headfirst in a trash can next to the bed. The grandmother picked the child up and realized he did not have a pulse. The grandmother began cardiopulmonary resuscitation and the babysitter called 911. First responders arrived and transported the child to the hospital where he was intubated and placed on life support. The child underwent brain death testing and was determined to be brain dead. The child was removed from life support and died on 6/10/23 at 10:25 PM.

An autopsy was performed and the final results were not yet available at the time the CPS investigation was closed. ACS spoke with the medical examiner's office and it was reported the preliminary cause of death was asphyxia. There were no findings of trauma to the child. Law enforcement's investigation did not reveal there was any criminality regarding the child's death.

The allegations of Inadequate Guardianship and DOA/Fatality against the grandmother and babysitter were substantiated. ACS determined that while in the care of the grandmother and babysitter, the child was placed to sleep in an unsafe sleeping environment, including on an adult-size bed with multiple pillows. The child rolled off the bed into a garbage can with a plastic liner. The preliminary cause of death was asphyxia. ACS provided the family with funeral assistance. The grandmother and parents were offered bereavement counseling but declined. The CPS investigation was indicated and closed on 8/8/23.

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:
There were no surviving siblings or children in the home; therefore, the completion of the safety assessment tools was not required. The determination was supported by the evidence gathered during the investigation.

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:
Casework activity was commensurate with case circumstances. Once all casework requirements were met, the CPS investigation was appropriately closed.

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: 06/10/2023 **Time of Death:** 10:25 PM

Date of fatal incident, if different than date of death: 06/09/2023
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Queens
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? 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	Male	5 Month(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	No Role	Female	37 Year(s)
Other Household 1	Aunt/Uncle	No Role	Male	35 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	66 Year(s)
Other Household 1	Other Adult - Babysitter	Alleged Perpetrator	Female	48 Year(s)
Other Household 1	Unrelated Home Member	No Role	Female	18 Year(s)

LDSS Response

Upon receipt of the SCR report on 6/12/23, ACS coordinated efforts with law enforcement, sent notification to the Medical Examiner and district attorney's office, interviewed the family, and gathered information from medical collaterals.

ACS interviewed the mother and father at their home regarding the incident. On the morning of 6/9/23, the father said goodbye to the mother and child and left for work around 7:00 AM. The mother left the home with the child and met with the babysitter at the drycleaners around 12:30 PM. The mother, babysitter, and child went to the grandmother's home, where the mother left the child with the babysitter around 2:00 PM. The mother returned home, got ready, and went to the grandmother's business to work. Around 6:20 PM, the mother was notified by the hospital that they were looking for the child's mother and told her to come to the hospital. The mother notified the father regarding the call and they both went to the hospital.

The parents reported that the child was healthy other than a digestive disease, for which the child was being seen by a specialist. The child was developmentally on target and last seen by his pediatrician in April 2023. While at the grandmother's, the child would typically sleep on an adult bed surrounded by pillows. ACS educated the parents on safe sleep practices. It was unclear where the child slept at the parents' home, though ACS observed a crib and bassinet during their visit. The mother reported she did not provide the babysitter and grandmother with a bassinet or crib.

ACS interviewed the grandmother who reported the child was at her home the day of the incident so the mother could do some work at the grandmother's business. The grandmother reported the child was dropped off by the mother and fell asleep in the upstairs part of the home where the babysitter resided. The grandmother had her nephew and friend over. While they were in the living room, the babysitter brought the child downstairs and placed him to sleep in a bedroom adjacent to the living room. The grandmother's company left around 4:00 PM and the grandmother checked on the child periodically. The third time the grandmother checked on the child he was facedown. The grandmother adjusted the child's head, put his thumb in his mouth, and left the room. When the grandmother went to check on the child again she did not see him on the bed. The grandmother asked the babysitter where he was and she did not know. The grandmother and babysitter located the child in the garbage can between the bed and the dresser. The child had no pulse and the

grandmother started CPR and the babysitter called 911. The grandmother reported that the child must have rolled off the bed into the garbage can. The grandmother was unable to provide a timeframe for the events. When ACS inquired about the child's sleeping arrangements, the grandmother reported the mother told her it was okay for him to sleep on the bed with pillows around him. ACS educated the grandmother on safe sleep practices. The grandmother reported no concerns for the babysitter.

ACS attempted to interview the babysitter; however, she obtained an attorney and refused to cooperate. The babysitter reported she was being unfairly blamed for the death by the family. ACS legal attempted to arrange an interview via the babysitter's attorney, but the babysitter continued to refuse an interview. The babysitter reported to law enforcement that around 2:00 PM she fed and burped the child and placed him to sleep. The babysitter left the child downstairs in a guest bedroom on a full-size bed with two pillows on the side of him so he would not roll.

ACS completed home visits to the parents' and grandmother's homes, requested medical and law enforcement records, completed a CPS history check, and interviewed all appropriate family members and collaterals. Fatality-related services were offered to the family and they were provided a list of community-based resources.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065097 - Deceased Child, Male, 5 Mons	065100 - Grandparent, Female, 66 Year(s)	DOA / Fatality	Substantiated
065097 - Deceased Child, Male, 5 Mons	065100 - Grandparent, Female, 66 Year(s)	Inadequate Guardianship	Substantiated
065097 - Deceased Child, Male, 5 Mons	065102 - Other Adult - Babysitter , Female, 48 Year(s)	DOA / Fatality	Substantiated
065097 - Deceased Child, Male, 5 Mons	065102 - Other Adult - Babysitter , Female, 48 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?	☒	☐	☐	☐
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 babysitter hired an attorney and refused to be interviewed by ACS.

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 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	☐	☐	☐	☐	☐	☒	☐

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 was 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