Child Fatality Report

Report Identification Number: SV-24-047

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

Issue Date: Mar 04, 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: 10 month(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 10/21/2024
Initial Date OCFS Notified: 10/21/2024

Presenting Information

An SCR report was received that alleged on 10/21/24, around 2:40PM, the babysitter put the 10-month-old in a Pack 'N Play to sleep. The babysitter checked on the subject child around 2:59PM and realized that she was not breathing. The babysitter immediately called 911. Emergency medical services responded to the residence and transported the subject child to the hospital. Despite life saving measures, the subject child was pronounced deceased at 3:57PM. The subject child was an otherwise healthy child, and the babysitter did not have an explanation for her death.

Executive Summary

On 10/21/24, Westchester County Department of Social Services (WCDSS) received an SCR report regarding the death of the 10-month-old female child. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the babysitter. At the time of her death, the subject child was being cared for by her babysitter. WCDSS immediately initiated their investigation and learned the subject child resided with her parents and there were no surviving siblings.

Through a joint investigation with law enforcement, it was learned that on 10/21/24, the subject child was in the care of her babysitter. Around 3:00PM, the babysitter found the subject child unresponsive in her Pack 'N Play. The babysitter yelled to a family member for help and immediately initiated life-saving efforts while the family member contacted 911. Emergency medical services arrived, took over life-saving efforts, and transported the subject child to the hospital. Despite efforts, the subject child was pronounced deceased on 10/21/24 at 3:57PM.

WCDSS communicated with the medical examiner's office and learned an autopsy was performed. The external examination revealed no indications of "abuse or maltreatment." Testing was negative for illness and there were no prior medical conditions found that could have contributed to the death. The medical examiner stated, "it stands to reason that the overdressing coupled with the heat in the room impacted the child's ability to regulate her temperature and as a result, she suffered from dehydration and subsequent hyperthermia." In addition, when the child was found her clothes were soaked which showed she was excessively perspiring. The medical examiner also stated, "overdressing and the environment were factors that led to the child's death." At the time this report was written, the final autopsy report had not yet been received.

WCDSS communicated with the district attorney's office and law enforcement. WCDSS learned the babysitter's residence was observed to be clean. It was reported the temperature of the home was 78 to 80 degrees and was noted to be "very hot." The Pack 'N Play was observed and there were no items found inside. The windows were closed in the room where the Pack 'N Play was found and there was no ventilation. At the time of case closure, it appeared the criminal investigation was ongoing.

WCDSS communicated with OCFS Daycare Licensing and learned the babysitter cared for more than 2 non-relative children for more than 3 hours per day and was operating an unlicensed/unregistered daycare program. The babysitter was provided a cease and desist letter. OCFS Daycare Licensing continued to monitor the babysitter who consistently declined to apply for licensing but agreed to reduce the number of children she cared for.

WCDSS substantiated allegations of Inadequate Guardianship and DOA/Fatality against the babysitter. The babysitter was aware the temperature in the home was hot and failed to remove the subject child's multiple layers of clothing, resulting in her being unable to regulate her body temperature. In addition, the subject child's clothing was "soaked in sweat," despite being checked on several times throughout the day. Due to this, the subject child suffered from dehydration and hyperthermia which resulted in her death. WCDSS contacted numerous collateral sources such as family members, the pediatrician, the medical examiner's office, and law enforcement. The record reflected sufficient supervisory consultation and that the case was discussed with their local Child Fatality Review Team on 10/30/24. Progress notes were entered contemporaneously and were thorough. Safe sleep was discussed, required notices were provided, and the investigation was closed timely on 12/20/24.

Bereavement services were discussed with the mother and father; however, both declined.

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:
WCDSS made an appropriate decision to substantiate the allegations of DOA/Fatality and Inadequate Guardianship based on evidence obtained throughout their investigation.

Was the decision to close the case appropriate? N/A

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.

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: 10/21/2024 **Time of Death:** 03:57 PM

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

County where fatality incident occurred: Westchester
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? Unknown
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	10 Month(s)
Deceased Child's Household	Father	No Role	Male	32 Year(s)
Deceased Child's Household	Mother	No Role	Female	22 Year(s)
Other Household 1	Other Adult - Babysitter	Alleged Perpetrator	Female	43 Year(s)

LDSS Response

Upon receipt of the SCR report, WCDSS initiated their investigation within 24 hours, completed a CPS history check which revealed no prior history, and coordinated their efforts with law enforcement, and the district attorney. WCDSS immediately initiated their investigation and learned there were no surviving siblings.

WCDSS interviewed the babysitter at the home where the fatality occurred. During her interview, she explained the subject child was dropped off on 10/21/24, around 6:30AM. She noted the subject child did not appear to be her "usual self"; the child was not as playful and was not smiling as much as she normally did. The babysitter denied the subject child had a fever and reported she coughed up phlegm once but was not overly concerned. The babysitter noted the mother

instructed her not to open the windows or turn on the air conditioning due to the child being recently sick. At 8:30AM, the babysitter put the subject child down for a nap for about 50 minutes. The subject child then played and was fed a 4oz bottle of formula at 10:30AM and at 12:30PM; however, the subject child did not eat during the second feeding. Around 2:30PM, she was put back down for a nap in a Pack 'N Play with no objects. The babysitter checked on the subject child around 3:00PM and noticed she was not breathing. She picked up the child and immediately started "mouth to mouth" while a family member called 911. The babysitter continued resuscitative efforts until she heard the ambulance and ran outside with the child and handed her to first responders. The babysitter later learned that the child passed away. The babysitter denied providing the child any medications or being instructed to; however, did report she was told to keep the subject child "warm."

WCDSS spoke with the family members who resided in the home where the fatality occurred and that were present at the time of the incident. The family member confirmed the babysitter's timeline of events and responded to her request for help when the subject child was found unresponsive. The family member confirmed he contacted 911 while the babysitter brought the child outside to wait for first responders. Another family member confirmed the babysitter had cared for children for over a decade and denied having any concerns for the babysitter caring for children in the home.

WCDSS interviewed the mother at her residence. During her interview, the mother provided information regarding what the subject child was wearing the day of the fatality. The mother explained the subject child was dressed in a short sleeve onesie, a long sleeve onesie and a long sleeve sweatshirt with pants. The mother reported she instructed the babysitter to remove clothing "accordingly." The mother denied telling the babysitter to not use the air conditioner. The mother acknowledged the child was ill two weeks prior to the fatality, but denied the child showed symptoms of illness on the day of the incident.

WCDSS interviewed the father at his residence. During his interview, he explained the subject child was dropped off to the babysitter in the morning. The father reported he was notified by the babysitter something was wrong with the subject child. The father denied the subject child had any preexisting medical conditions.

WCDSS communicated with the subject child's pediatrician. There were no concerns noted for her physical health, and she was up to date with her immunizations.

The CPS investigation was closed timely on 12/20/24. The babysitter was offered preventive services which she accepted.

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? Yes
Comments: Westchester County referred this case to their local Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070248 - Deceased Child, Female, 10 Month(s)	070251 - Other Adult - Babysitter, Female, 43 Year(s)	DOA / Fatality	Substantiated
070248 - Deceased Child, Female, 10 Month(s)	070251 - Other Adult - Babysitter, Female, 43 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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
WCDSS offered the babysitter preventive services which she accepted and included services such as parent training and early childhood educational services.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
Bereavement services were offered to parents but declined. In addition, preventive services were offered to the babysitter which she accepted.

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? Yes

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