



Report Identification Number: NY-19-114

Prepared by: New York City Regional Office

Issue Date: Feb 20, 2020

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
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		
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	
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	ASTO-Allowing Sex Abuse to Occur	



Case Information

Report Type: Child Deceased
Age: 1 month(s)

Jurisdiction: Queens
Gender: Male

Date of Death: 10/16/2019
Initial Date OCFS Notified: 10/16/2019

Presenting Information

On 10/16/19, at 3:24 PM, the five-week-old male SC passed away. The SM took the child out shopping and while waiting in the train station for the train home she discovered the child was limp and bleeding from the mouth as he sat in the stroller. The SM began to perform CPR on the SC then left the train station, got into a cab and took the SC to the hospital. The SM and SC arrived at the hospital at approximately 3:00 PM. Resuscitation efforts were initiated; however the SC expired. The SC was otherwise a healthy child.

Executive Summary

On 10/16/19, the SCR registered a report regarding the death of a five-week-old male. ACS' Queens Field Office initiated the investigation by contacting Elmhurst Hospital (EH) within the required timeframe. The ACS Specialist also spoke to LE and the family of the deceased child and received information regarding the incident. There were no other children residing in the home.

The Specialist learned from the attending Dr. in the ER that the SM and MGM brought the SC in and he appeared limp, pale and bled from his nostrils not from his mouth as reported in the narrative. CPR was rendered with no results; the SC was pronounced dead on 10/16/19 at 3:24 PM. The Dr. reported there were no signs of maltreatment or abuse found on the SC.

The ACS Specialist learned from LE and the family that the SM took the five-week-old SC out shopping, accompanied by the MA, MU and the MGM, who was visiting from their native country. The SM fed the SC and placed him in the stroller just before they entered the train station. The SM noticed the SC appeared unresponsive and she initiated CPR. The family summoned 911 for medical assistance; however, the SM believed emergency services took too long and she opted for a cab to the ER. They arrived at the hospital within ten minutes. EMS reported they received multiple calls from the train station for medical assistance relating to this incident.

The Specialist interviewed the SM, MGM, MA and MU separately and their accounts of the incident were similar. The BF reported the SC cried constantly; however, the SM told the ACS Specialist the SC showed no signs of illness and had no medical conditions and it was confirmed by the pediatrician. The parents denied drug or alcohol use, DV or mental illness and the family members reported the same.

According to ACS' case documentation, the SM has a seventeen-year-old daughter who resides in another country and is doing well. The case documentation also reflected that the BF has a two-year-old son that resides with the child's mother and a three-year-old sister. ACS provided safe sleep information to the mother and a pack and play for the SC's half-sibling. ACS assessed the children's safety and deemed them safe. The parents accepted bereavement counseling in their community, in addition to support from the SM's religious affiliation.

On 1/14/2020, ACS unsubstantiated the allegations of DOA/fatality and IG of the SC by the SM. ACS cited the ME's report that listed the cause and manner of the SC's death undetermined. ACS documented they found no credible evidence to substantiate the allegations against the SM. ACS closed the case.

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:

ACS appropriately unsubstantiated the DOA/fatality and IG allegations.

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: 10/16/2019

Time of Death: 03:24 PM

Time of fatal incident, if different than time of death: 02:50 PM

County where fatality incident occurred: Queens

Was 911 or local emergency number called? Yes

Time of Call: Unknown

Did EMS respond to the scene? No

At time of incident leading to death, had child used alcohol or drugs? No

Child's activity at time of incident:

- | | | |
|--|----------------------------------|---|
| <input checked="" type="checkbox"/> Sleeping | <input type="checkbox"/> Working | <input type="checkbox"/> Driving / Vehicle occupant |
| <input type="checkbox"/> Playing | <input type="checkbox"/> Eating | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other | | |



Did child have supervision at time of incident leading to death? Yes

At time of incident supervisor was: Not impaired.

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	1 Month(s)
Deceased Child's Household	Father	No Role	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Other Household 1	Sibling	No Role	Female	17 Year(s)
Other Household 2	Sibling	No Role	Male	2 Year(s)

LDSS Response

On 10/16/19, the ACS Queens Field Office initiated the investigation within the required timeframe by contacting EH, LE and the parents. ACS learned there were no other children residing in the home.

The attending Dr. reported the SC was brought into the ER by the SM and the MGM. The Dr. observed the SC's body was pale and limp in the SM's arms. The SC was not breathing and did not have a heart rate. Resuscitation efforts were applied; however, the SC did not respond. The time of death was 3:34 PM. There were no injuries observed on the SC's body. The SC was born full term with no complications and at the SC's last medical appointment on 10/11/19 he had no medical conditions. The ACS Specialist used a language interpreter to assist with interviewing the entire family.

LE reported the SM and MGM gave similar details of their accounts leading to the SC's demise. LE went to the home and reported it contained a crib in the parents' bedroom along with ample food and provisions; it was clean and orderly. LE found no criminality. The ME listed the cause and manner of death, undetermined.

The SM reported she fed the SC at approximately 2:45 PM and placed him in the stroller to sleep. The SM along with other family members entered the train station. While they were on the platform, the SM checked the SC, who was partially covered from the waist down with a baby blanket. She observed the SC unresponsive. She initiated CPR and summoned 911 for emergency medical assistance. The SM reported she left the train platform and when she arrived outside, the SC nose was bleeding. The SM took a cab to EH because of its proximity. The cab ride was between five and ten minutes from the train station to the ER.

The BF reported the SC cried more than normal and they took him to the ER on 9/7/19, due to his constant crying and the Dr. told the parents the child was well. On the morning of 10/16/19, the BF observed the SC in the before he left for work and the SC and there were no concerns. While at work, the BF viewed the SC on facetime at approximately 1:30 PM and he appeared well. Approximately two hours later, the SM called and alerted him of the incident.

ACS learned from the parents that they each have another child outside of the home. The SM has a seventeen-year-old child who resides in another country with her family. ACS spoke to that child via telephone and she told ACS she was doing well. The BF has a two-year-old son who resides with his mother. The Specialist visited that home to assess the child who was deemed to be safe. During that visit, ACS provided information on safe sleep practices and a playpen for



the two-year-old sibling.

Both parents denied DV, alcohol or drug use or mental health conditions. The MA and the PU who resided at the home with the parents reported the child was loved by everyone; but the SM provided all care. The MGM resided in another country and was visiting the family at the time of the incident. ACS interviewed the other family members and they were very supportive of the parents and stated they were very good parents.

ACS unsubstantiated the allegations of DOA/fatality and IG of the SC by the SM. ACS cited the ME's report and the finding of their investigation and stated they found no credible evidence.

Official Manner and Cause of Death

Official Manner: Undetermined

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)?No

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053101 - Deceased Child, Male, 1 Mons	053102 - Mother, Female, 39 Year(s)	DOA / Fatality	Unsubstantiated
053101 - Deceased Child, Male, 1 Mons	053102 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain:
ACS provided a service referral to the parents for bereavement counseling and they accepted.

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Foster care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Legal services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Homemaking Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Parenting Skills	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Domestic Violence Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Early Intervention	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Child Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A

Explain:

There were no other children residing in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

The parents received privately arranged services from the community in which they reside.

History Prior to the Fatality

Child Information

- Did the child have a history of alleged child abuse/maltreatment? 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 in NYS within three years prior to the fatality.

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

There was no CPS 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