



Report Identification Number: NY-23-048

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

Issue Date: Oct 24, 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
Age: 1 year(s)

Jurisdiction: Queens
Gender: Male

Date of Death: 05/21/2023
Initial Date OCFS Notified: 05/21/2023

Presenting Information

An SCR report alleged on 5/21/23, at an unknown time the aunt observed the subject child asleep and snoring. At an unknown time, the mother found the child unresponsive. The father did not call EMS and the parents drove the child to the hospital in their vehicle. The family arrived at the hospital at about 9:30AM, and the child had no pulse and was unresponsive. Hospital staff performed resuscitative measures; however, they were unsuccessful, and the child was pronounced deceased at 10:19AM. The child was otherwise healthy, and the parents had no explanation for the child's death.

Executive Summary

This fatality report concerns the death of a 1-year-old male subject child that occurred on 5/21/23. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother, father, and maternal aunt. At the time of the death, the subject child resided with his parents and maternal aunt. There were no surviving siblings.

New York City Administration for Children's Services (ACS) completed collateral and casework contacts and learned the aunt was watching the subject child while the mother worked nights. On 5/21/23, the child woke up around 5:00AM and the aunt changed his diaper. Around 8:00AM, the mother was on her way home from work when the aunt contacted her stating the child was breathing irregularly and sent her a video of the child's condition. When the mother arrived home, she immediately checked on the child and gave him a saline nebulizer treatment. After the treatment, the child's breathing improved, and the mother went to sleep. At about 9:00AM, the aunt woke the mother and told her the child was still sleeping. The mother went to wake up the child and found him unresponsive. The mother screamed and woke the father. The parents reported they did not think to call 911. The father drove the child, the mother, and the aunt to the hospital; the child did not wake up during the drive and the mother said the smell of the child's breath was different. Upon arrival at the hospital, the child was not breathing, had no pulse, and no heart rate. Hospital staff began life-saving measures; however, were unsuccessful and the child was pronounced deceased at 10:19AM.

An autopsy was performed; however, the final autopsy report had not yet been received at the time this report was written. The medical examiner found no signs of abuse or trauma to the child internally or externally. The cause of death was pending further testing. Law enforcement investigated the child's death and found no criminality regarding the death and closed the criminal investigation.

Bereavement services were offered to the family, and they accepted. ACS made a referral for services; however, the mother left the country after the child's funeral, and it was unknown if the father or the aunt engaged with services. Burial assistance was offered to the family, and the parents declined. ACS determined there was not a fair preponderance of evidence to support the parents or the aunt failed to provide a reasonable minimum degree of care for the child. ACS unsubstantiated the allegations of Inadequate Guardianship and DOA/Fatality against the mother, father, and maternal aunt regarding the child. The CPS investigation was unfounded and closed on 6/30/23.

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? 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 made an appropriate determination based on the evidence obtained throughout 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 the 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: 05/21/2023

Time of Death: 10:19 AM

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

County where fatality incident occurred: Queens

Was 911 or local emergency number called? No

Did EMS respond to the scene? No

At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown

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 | | |



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	Aunt/Uncle	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)

LDSS Response

Within the first 24 hours of the investigation, ACS contacted the source of the report, completed a CPS history check, coordinated their investigation with law enforcement, and notified the medical examiner and district attorney’s office of the death. Throughout the investigation ACS completed interviews with the parents, the MA, and medical staff.

ACS completed a home visit to the family’s residence and interviewed the mother, the father, and the MA. There were no concerns for the condition of the home. ACS learned the father left the home on 5/19/23, at about 8:30PM, and returned home on 5/21/23 around 1:30AM, and he went to sleep in the basement. The father did not know what time it was but said he was awoken by the mother and the MA screaming there was something wrong with the SC. The mother told ACS the week prior to the SC’s death, everyone had been sick with a virus and diarrhea. The mother contacted the pediatrician and was advised to give the SC Pedialyte and keep him hydrated. On 5/20/23, the mother reported the SC took a nap from 4:00-7:30PM, and she had to wake him up. The mother said it was unusual for the SC to nap that long. When the SC woke up his eyes were swollen, and he had wet the bed. The mother cleaned up the SC, fed him dinner, and he appeared to be better. The mother got ready for work and the MA watched the child while the mother went to work. The MA reported the SC went to sleep shortly after the mother left for work. On 5/21/23, at about 5:00AM, the MA woke up and changed the SC’s diaper; however, the SC did not want a bottle and he went back to sleep. The MA called the mother at about 8:00AM, and said the SC was breathing irregularly and she had taken a video of the SC's breathing. The mother arrived home and immediately checked on the SC; she gave him a saline nebulizer treatment and his breathing improved. Around 9:00AM, the aunt woke the mother and said the SC was still asleep. The mother went to wake the SC and he was unresponsive. The mother screamed and the father came upstairs, and he immediately drove the SC to the hospital. When the parents arrived at the hospital the SC had no pulse and was not breathing. A nurse took the child from the parents and hospital staff began life-saving efforts.

ACS spoke with collateral contacts including, relatives, day care staff, and law enforcement. There were no reported concerns for the child, the parents or the MA. ACS also learned through the investigation that the SC was taken out of the country in February 2023, and had his adenoids removed. The mother and SC returned home in March 2023 and the child was doing well. ACS spoke with the pediatrician; the child was last seen for his well child visit in April of 2023 and there were no medical concerns noted for the SC.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending

Person Declaring Official Manner and Cause of Death: Unknown



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: 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
065078 - Deceased Child, Male, 1 Yrs	065079 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
065078 - Deceased Child, Male, 1 Yrs	065079 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
065078 - Deceased Child, Male, 1 Yrs	065080 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated
065078 - Deceased Child, Male, 1 Yrs	065080 - Father, Male, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
065078 - Deceased Child, Male, 1 Yrs	065081 - Aunt/Uncle, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
065078 - Deceased Child, Male, 1 Yrs	065081 - Aunt/Uncle, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input 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 type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<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"/>

Additional information:

There were no surviving siblings.



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"/>

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

Additional information, if necessary:

Bereavement services were offered to the family, and they accepted. ACS completed a referral for services; however the mother left the country after the death and it was unknown of the father and the aunt engaged with services. There were no surviving siblings.



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 surviving siblings.

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

Explain:

ACS offered the family bereavement services, and they 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

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