Child Fatality Report

Report Identification Number: NY-18-044

Prepared by: New York City Regional Office

Issue Date: Sep 27, 2018

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		

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 05/03/2018
Initial Date OCFS Notified: 05/03/2018

Presenting Information

An SCR report was received on 5/3/18, alleging that on 5/2/18, the SM left the SC unattended in his bedroom. The SC required 24-hour care and supervision due to medical issues that required a tracheostomy tube (trach tube) to assist with his breathing. As a result of the SM's failure to supervise the SC, the trach tube became dislodged from his throat. The SC subsequently went into cardiac arrest and became unresponsive. The SC died as a result of the incident.

Executive Summary

This report concerns the death of the 4-year-old male SC. On 5/3/18, ACS received an SCR report regarding the SC's death. There was a concern the SM had left the SC unattended in the time leading to his death. ACS learned the SC was a medically fragile child. The SC was born prematurely with underdeveloped lungs and severe respiratory issues. Since the SC's birth, he took several medications and required 24 hour care due to a trach tube and gastrointenstinal feeding tube.

During the early morning hours of 5/3/18, the SC's trach tube became disconnected, causing the SC to not have proper airflow into his body. The SC was being cared for by his evening nurse, while the SM, both SS and the BF of the 2yo SS were asleep in the home. The nurse yelled for help while he administered CPR to the SC. The eldest SS and SM were alerted and called 911. The nurse, SM and EMS were unable to reconnect the SC's tube and he was taken to the ER. The SC died as the result of the incident.

The ME performed an autopsy and the report was not complete at the time of this writing, therefore the cause and manner of death were pending determination. LE jointly investigated the death of the SC and had not made an arrest at the time this report was written. LE was unsuccessful in their attempts to interview the nurse that was on duty at the time of the fatal incident. The nurse had retained an attorney and neither the attorney nor the nurse would speak with LE or ACS. ACS followed protocol in notifying LE and working with the investigative consultant during the investigation.

ACS spoke with all the SC's medical providers, the SS school, family members and first responders throughout their investigation. ACS also gathered information from an investigative and medical consultant. ACS made multiple home visits and continually assessed the safety of the SS. ACS asked the SM for information regarding the biological fathers' of the SC and 17yo SS, but she was not cooperative in providing this information. There is no documentation in the case record regarding contact with the BF of the SC, although the BF of the 17yo SS was sent a notice of existence of the report. At the time this report was written ACS had not yet made a determination and the investigation remained open.

ACS offered the family assistance with burial expenses and referrals for daycare services, bereavement counseling and early intervention. The SM took the 17yo SS to a therapist and refused all bereavement services for herself.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of receipt of this report. The PIP will identify action(s) 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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The case remained open at the time of this writing.

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:
The investigation remained open at the time of this writing.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Fatality Report was completed and approved on 5/7/18 and the SCR report was received on 5/3/18.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must complete a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Fatality Report was completed on 6/11/18 and the initial SCR report received on 5/3/18.

Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must complete a 30-Day Fatality Report within 30 days of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	There was no 7-Day Safety Assessment completed.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-Day Safety Assessment was completed on 6/11/18 and the SCR report received on 5/3/18. Additionally, The 30-Day Safety Assessment was never approved in Connections.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 30-day safety assessment in Connections.
Issue:	Failure to provide notice of report
Summary:	ACS failed to provide a notice of existence of an SCR report to the BF of the SC. There was no casework documentation that attempts were made to identify and locate the BF.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/03/2018 **Time of Death:** 01:19 AM

Time of fatal incident, if different than time of death: 12:00 AM

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 alcohol or drugs? No
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown

☐ Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Unknown if they were 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	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Other - Parent Substitute	No Role	Male	38 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

ACS began the investigation into the death of the SC after receiving an SCR report on 5/3/18. ACS conducted a CPS history search for the family, contacted the source of the report, LE, and notified the DA. ACS made a visit to the SC's home within 24 hours of receiving the report and assessed the safety of the SS.

ACS learned the SC resided in the home with his SS (ages 17 and 2), the SM and the BF of the 2yo SS. The SC received 24-hour in home nursing care due to multiple medical problems. All the household members, in addition to a night nurse were present at the time of the fatal incident. ACS inquired about the SC and SS biological fathers' and the SM was not cooperative in providing the information. ACS found the identity of the 17yo SS BF and sent him a notice of existence letter. There is no documentation in the case record that the BF of the SC was identified, nor was either absent BF interviewed.

On the evening of 5/2/18, the SM and BF of the 2yo SS reported they were asleep in the living room of the home with the 2yo SS, while the SC was in his bedroom with the night nurse. The BF was asleep on and off through the night and did hear the SC's machine beeping as it normally did. He heard the commotion and went into the SC's room to find the nurse doing CPR and the SM speaking to 911. The SM walked by the SC's room around 10:30PM and saw him lying on his bed and playing on his phone and she then went to sleep. The SM stated that the 17yo SS woke her up between 12-12:30AM on 5/3/18 to tell her the SC was in distress. The SM went into the SC's bedroom and saw the SC's trach tube was not in, and the nurse was performing CPR. The SM did not initially see the tube, but later found it under the blankets. The SM told the SS to call 911. The SM then spoke with 911 because the SS was unable to speak clearly. The SC was taken to the ER and was in cardiac arrest. He was unable to be revived. The SM denied the trach tube became easily loosened when in place. The SM reported the nurse had previously had trouble positioning the SC to change his trachea ties and she blamed the nurse for the SC's death. She also reported that the nurse was forgetful and she kept a log with instructions for him on the wall in the SC's room. The SM expressed she believed the nurse panicked the evening of the incident and hesitated in calling 911 immediately. The SM had previously complained about the nurse to his supervisor and was directed to give him another chance to improve. The SM and BF denied alcohol or drug use.

The 17yo SS told ACS he was in his room and heard the nurse screaming for help between 12-12:30AM. The SS said the SC's machine was making noise and he immediately went into the SC's bedroom. The nurse was giving the SC CPR, and the SS went to wake the SM. The SS then called 911 and the SM spoke with the operator because he could not talk. The SS denied the SC was ever alone and stated the last person to see him alive was the nurse.

ACS attempted to speak with the nurse, but he refused to speak with them and had retained an attorney. ACS did speak with the clinical nursing manager where the nurse was employed. She would not allow ACS to speak to the other nurse and reported she would speak on her behalf. She acknowledged the SM's complaints about the night nurse and believed although the nurse was trained he was not confident in the SC's care.

ACS spoke with the SC's various medical providers and they all reported the SM was very well versed in caring for the SC and meeting his medical needs, despite having 24-hour nursing care since 3/2015. The SM was described as a strong advocate for the SC, and there were no concerns regarding her care of the SC.

The ER doctor told ACS the SC presented at the hospital with his trach tube dislodged, and therefore was not properly ventilated. The Dr. reported it is common for a tube to become loose, especially in children. The ER staff put the tube in, but the SC had already passed away.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or 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 reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047589 - Deceased Child, Male, 4 Yrs	047592 - Mother, Female, 35 Year(s)	Lack of Supervision	Pending
047589 - Deceased Child, Male, 4 Yrs	047592 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending
047589 - Deceased Child, Male, 4 Yrs	047592 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending

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 BF of the 17yo was added to the report and sent a notification of the report, but never interviewed. The BF of the SC was not identified, sent notice, or interviewed.

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 safety 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:
The SM waivered in accepting several services offered. The case remained open at the time of this writing and it is unknown if the SM and BF of the 2yo SS accepted additional service referrals.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The SM arranged for the 17yo SS to see a therapist after the death of the SC. ACS also made a referral for bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS offered the SM and BF of the 2yo SS bereavement counseling, daycare services, and assisted with burial expenses.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? 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? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/22/2015	Deceased Child, Male, 2 Years	Mother, Female, 33 Years	Sexual Abuse	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received alleging the SC (who was 2 years old at the time) was being sexually abused. The SC became frightened and began to cry and physically pull away while his diaper was being changed. The SM was the primary caretaker and therefore the alleged subject.

Report Determination: Unfounded | **Date of Determination:** 02/19/2016

Basis for Determination:
ACS found no evidence to support the allegations. The SC was found to be supervised by the SM and his medical

caregivers 24-hours a day. The SC's nurse had no concerns. The SC's doctor reported seeing the SC regularly for his medical condition and also denied any concerns. The SM denied issues around the SC's diaper changes.

OCFS Review Results:
The safety of the SC and older SS was assessed at multiple home visits. Collateral contacts were made and the safety assessments were completed timely. Absent parents were not identified and notified of the investigation.

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

Issue:
Failure to provide notice of report

Summary:
ACS inquired about absent fathers during the investigation, and the SM refused to provide any information. ACS did not use additional resources to identify and locate the fathers. The father of the SC and father of the SS were not notified of the CPS investigation.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
ACS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

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

An SCR report was received 12/16/2008-2/13/2009 with allegations of C/T/S and IG Unsub against the SM regarding the SS.
An SCR report was received 11/3/2008-12/12/2008 with an allegation of IG Unsub against another adult regarding the SS.
An SCR report was received 1/29/2008-3/31/2008 with allegations of XCP and IG Sub against the SM regarding the SS. An additional allegation of L/B/W was Unsub against the SM regarding the SS.
An SCR report was received 1/22/2008-3/20/2008 with allegations of XCP, IG and L/B/W Sub against the SM regarding her nephew.
An SCR report was received 1/3/2002-02/27/2002 as the result of a court ordered investigation. The allegations of IG and OTH/COI were Sub against the BF of the SS, regarding the SS.

Known CPS History Outside of NYS

There is 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