Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-127

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

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This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 5 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 12/24/2023
Initial Date OCFS Notified: 12/24/2023

Presenting Information

An SCR report was received alleging the 5-year-old subject child was medically fragile and had a medical condition that required her to have a tracheostomy tube to breathe. On 12/24/23, sometime before 10:36AM, the subject child pulled the tracheostomy tube out. The subject child was unable to breathe for an unknown period and as a result, she died. The subject mother found the subject child unresponsive, blue and not breathing around 10:36AM and called 911. EMS arrived at 10:40AM, at which point the subject child was already medically deceased. EMS attempted to resuscitate the subject child and transported her to the hospital where she was pronounced dead. Given that the subject child was medical fragile and there was a possibility of her pulling out the tube or having it dislodged it was alleged the subject mother, subject father and maternal grandmother all failed to provide adequate supervision of her that morning.

Executive Summary

New York City Administration for Children's Services (ACS) received an SCR report on 12/24/23, regarding the death of the 5-year-old subject child. The report contained allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the subject mother, subject father, and maternal grandmother. At the time of her death, the subject child resided with her mother, father, maternal grandmother and maternal uncle. ACS determined that there were no surviving siblings in the home.

ACS learned the subject child was found laying on the bedroom floor with her tracheostomy tube out. The subject mother immediately pushed the tube back into the subject child's mouth and placed her on the bed. The maternal uncle called 911 while the subject mother performed CPR. The subject child was transported to the hospital. ACS spoke with the attending doctor, and it was reported the subject child was pronounced dead at 11:50AM. The doctor reported there was no neglect on the part of the parents. The subject child was very sick and had numerous major medical diagnoses since birth. The tracheostomy tube being pulled out can happen in seconds and cannot be prevented unless the subject child is monitored every second of the day.

ACS spoke with the medical examiner's office and learned that there was no autopsy completed on the subject child at the parents' request. The manner of death was accidental, and the cause was Asphyxiation due to dislodged tracheotomy tube for the treatment of Bronchopulmonary dysplasia and chronic respiratory failure. ACS spoke with law enforcement and it was reported there was no suspicion of abuse or neglect. Law enforcement planned to close their case after receiving the official death certificate.

ACS offered the family burial assistance that the subject father declined due to the services already being paid for and completed. ACS provided both parents with a list of grief counselors. ACS appropriately unsubstantiated the allegation of Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the subject mother, subject father, and maternal grandmother.

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:
The SM, SF and MGM were unsubstantiated for IG, LS and DOA/Fatality regarding the SC. The SC had a serious medical condition and pulled out her breathing tube. The manner of death was accidental. There were no SSs; therefore, no safety assessments needed to be completed.

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:
The decision to close the case was appropriate as there were no SSs and no concerns that the SC passed away due to abuse or neglect from the caregivers. 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: 12/24/2023 **Time of Death:** 11:50 AM

Time of fatal incident, if different than time of death: 10:36 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 10:36 AM
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	Aunt/Uncle	No Role	Male	20 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	70 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS initiated their investigation within 24 hours, coordinated their efforts with law enforcement, and attempted to contact the source of the report. ACS reviewed prior CPS history, notified the district attorney, and CAC, and spoke with the medical examiner's office. ACS immediately determined that there were no surviving siblings in the home.

ACS spoke with the SM who reported, the morning of 12/24/23, was a typical day. She fed the SC as scheduled, at 4AM, 6AM and 9AM. All food and medications were administered through the SC's medical instrument. At the 9AM feeding the SM also administered the SCs daily medications. Around 10AM the SF left for work and a little later the SM left the SC in the bedroom to go to the bathroom where she administered her own medication. When the SM arrived back at the bedroom, she observed the door to be slightly cracked and was unable to push it open. Through the crack in the door, she observed the SCs legs. The SM and MGM were able to enter the bedroom together. They observed the SC laying on the floor looking as if she was asleep. The SCs tracheostomy tube was out. The SM immediately pushed it back into the SCs mouth and put the SC on the bed. The MU called 911 while the SM performed CPR. The SM met EMS downstairs in the lobby and brought them to the apartment. The SM reported the SC was wearing a onesie, so her entire body was covered, but her face was blue, and lips were black. This was the third or fourth time that the SC had taken out her tracheostomy tube. The last incident being about two months prior when the SF was able to immediately push the tube back into the SCs mouth. The SM notified the pediatrician regarding the SC pulling the tracheostomy tube out, but nothing could be done.

ACS spoke with the SF who reported, he left for work at 10AM and was not present during the incident. The last time the SC had pulled out the tracheostomy tube was about two months prior when he was napping, and he woke up when she began swinging her arms and hitting him. He immediately put the tube back in.

ACS spoke with the MU, who reported that it was a typical day for the family until he heard his sister scream. He ran to the bedroom where he observed his niece to not be breathing. When he was on the phone with 911, they instructed him to remove the SC from the bed and place her on the floor and administer CPR. The SC was dressed in her sleeper, but her face was blue, and lips were bluish black.

ACS spoke with the MGM, who reported the SC was playing in the bedroom when the SM stepped out to administer her

own medication. When the SM went back to the bedroom, she was unable to open the door. She retrieved the MGM and together they were able to get the door open. The SCs tracheostomy tube was out, and the SM immediately replaced it and put the SC on the bed.

ACS spoke with the SCs medical providers, including the Pediatrician, Cardiologist, Gastroenterologist, Pulmonologist, and Otolaryngologist. ACS learned the SC had numerous, major medical diagnoses since birth and had spent the first three years of her life in the hospital. She was released for the first time in May of 2021. The medical providers identified no concerns for the care of the SC by the parents and there was no way to guarantee the SC would not pull out her tube or have it fall out accidentally.

ACS contacted all necessary medical providers and made diligent efforts to communicate with law enforcement and the source. All surviving family members were seen and interviewed, and the home was visited. Progress notes were entered timely and accurately, and all required notifications were provided. Throughout the case there were several detailed supervisory notes. The investigation was completed accurately and timely.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From a 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 referred to an OCFS approved Child Fatality Review Team?No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066445 - Deceased Child, Female, 5 Year(s)	066446 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
066445 - Deceased Child, Female, 5 Year(s)	066446 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
066445 - Deceased Child, Female, 5 Year(s)	066446 - Mother, Female, 29 Year(s)	Lack of Supervision	Unsubstantiated
066445 - Deceased Child, Female, 5 Year(s)	066447 - Father, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
066445 - Deceased Child, Female, 5 Year(s)	066447 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
066445 - Deceased Child, Female, 5 Year(s)	066447 - Father, Male, 40 Year(s)	Lack of Supervision	Unsubstantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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 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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: The family was offered funeral assistance and provided with grief counseling resources.							

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:
No SS 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 family was offered burial assistance and grief counseling information and declined both.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? No

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.

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