Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-081

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

Issue Date: Jan 21, 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: 7 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 08/23/2024
Initial Date OCFS Notified: 08/24/2024

Presenting Information

An SCR report received on 08/23/2024, stated that at an unknown time, the mother left the 7-month-old subject child unsupervised on a bed. During that time, the subject child picked up a balloon and put it into his mouth. As a result, the ballon was lodged in the subject child's throat, causing him to cough. When the mother returned, she attempted unsuccessfully to extract pieces of the balloon from the subject child's throat. The mother called 911. Emergency medical services (EMS) arrived at an unknown time and transported the subject child to the hospital. The subject child arrived at the hospital at 8:44 PM and did not have a pulse. Despite medical staff administering cardiopulmonary resuscitation, the subject child was pronounced deceased at an unknown time. The father and the surviving sibling aged 2 had unknown roles.

Executive Summary

On 08/24/24, The New York City Administration for Children’s Services (ACS) received an SCR report regarding the death of the 7-month-old male subject child. The report alleged DOA/Fatality, Inadequate Guardianship and Lack of Supervision against the mother. The child lived with his parents and 2-year-old surviving sibling. ACS observed the home and SS and put a safety plan in place for the SS to have increased supervision. The SS was deemed to be safe with no immediate or impending danger of serious harm.

ACS conducted a joint investigation with law enforcement, it was learned that on 08/23/24, around 8:00 PM, the mother left the child alone with a balloon while helping the SS wash her hands. Upon returning to the subject child, the mother discovered the child to be chocking on the balloon. The mother and a roommate tried to get the balloon out of the child’s throat, however, were unsuccessful. The mother called 911, and first responders arrived at the home, initiated life-saving efforts, and transported the child to the hospital. Resuscitative efforts were unsuccessful, and the child was pronounced deceased upon arrival to the hospital.

An autopsy was performed, and the results were pending further studies at the time this report was written. The ME reported that there were no signs of child abuse or neglect, and that the death was believed to be caused by the child ingesting a balloon. The ME reported that there were remnants of a balloon found during the autopsy. Law enforcement investigated and completed an assessment of the home, which the parents consented to. The search of the apartment did not identify anything that would have been indicative of foul play. Law enforcement's investigation closed, and no arrests were made. The ADA was informed of the death and declined assignment as no arrests were made.

ACS appropriately assessed safety and risk. ACS substantiated the allegations against the mother, as they determined there was evidence in relation to the allegations in the report. ACS supported their determination by stating the evidence gathered through casework and collateral contacts gave cause to suspect that the mothers’ actions or inactions contributed to the child's death. The SM left the SC alone, to which the SC ingested a balloon causing his death. The CPS investigation was substantiated and closed on 10/02/24.

ACS offered the parents information on grief counseling, funeral assistance, and mental health counseling. The parents accepted the services offered and there was a services case was opened on 08/26/2024.

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?** Yes
- **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Casework activity was commensurate with case circumstances.

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:
ACS's level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion, was commensurate with the circumstances and appropriate.

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: 08/23/2024 **Time of Death:** Unknown

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

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 and/or ingested alcohol or drugs? N/A
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	Male	7 Month(s)
Deceased Child's Household	Father	No Role	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

Upon receipt of the SCR report on 08/24/24, ACS coordinated efforts with law enforcement, notified the district attorney and the ME, attempted contacting the source of report, spoke with medical collaterals, completed interviews with the family, and offered services related to the fatality. ACS set up a plan for the SS to have increased supervision.

ACS completed a home visit and interviewed the parents. The mother reported on 08/24/24, between 7:30 PM and 8:00 PM, she arrived at the home from a trip to the park with the two children. The mother reported that upon arrival she laid the subject child down on the living room floor and the child was playing with a balloon. The mother left the subject child on the floor and helped the SS to wash her hands in an adjoining room. The mother reports to be gone from sight of the subject child for approximately 1 minute. The mother looked in the living room and noticed the subject child put something in his mouth. The mother noticed the SC was choking. The mother did not remember hearing the balloon pop, however, did not see the balloon. The mother attempted to dislodge the balloon from the subject child's mouth without success. The mother yelled for the roommate and the roommate attempted to help in getting the balloon out of the subject child's mouth without success. The roommate used the mother's phone to call 911. Minutes later the mother made another call to 911. The mother, SS, SC, and roommate went outside of the home to wait for EMS. EMS arrived and transported the child to the hospital. The father was at work at the time of the incident.

ACS interviewed the father who stated that he was at work and upon arrival home the mother, SS and SC were outside the building with EMS. The mother told the father that the child had choked on a balloon. The father reported that the child was breathing when he arrived, and first responders transported the child to the hospital.

ACS inquired about domestic violence, discipline, supervision, and substance abuse. The parents reported no concerns. ACS discussed safe sleep, and the parents reported following safe sleep protocol with the SC. The parents stated they understood safe sleep guidelines and advised they were practicing safe sleep. A safe sleep environment was observed in the home for the SC.

ACS spoke to the pediatrician's office, who expressed no concerns about abuse or neglect by the parents. The parents kept scheduled appointments, and both children were up to date with immunizations. ACS spoke with the roommate who had no concerns for the safety of the SS while in the parents' care. The roommate confirmed the same events as the mother on the evening of the fatality.

ACS appropriately assessed safety and risk of the SS. ACS discussed drug and alcohol use with SM and father. Both parents denied any history or current drug or alcohol use. ACS opened a services case on 08/26/24 to help with providing for the family's service needs. Services were put in place for bereavement counseling for both parents, individual counseling for both parents, MH evaluation for the mother and parenting skills/ decision making skills for both parents. Burial services were not needed and declined by the parents.

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? 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
069516 - Deceased Child, Male, 7 Month(s)	069517 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated
069516 - Deceased Child, Male, 7 Month(s)	069517 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
069516 - Deceased Child, Male, 7 Month(s)	069517 - Mother, Female, 25 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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?	☒	☐	☐	☐
Was there an adequate 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	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
There was no removal of the SS as a result of the fatality investigation.

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	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
ACS offered the child and family bereavement services. ACS closed the CPS case and opened a services case upon closing to provide the child with counseling.

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:
ACS offered the family bereavement and burial services. There was an active services case open at the time of the CPS fatality case closing. Services were put in place for bereavement counseling for both parents, individual counseling for both parents, MH evaluation for the mother and parenting skills/ decision making skills for both parents. Burial services were not needed and declined by the parents.

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

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 is no know 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