Child Fatality Report

Report Identification Number: NY-22-053

Prepared by: New York City Regional Office

Issue Date: Dec 20, 2022

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	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: 6 day(s)
Jurisdiction: New York
Gender: Male
Date of Death: 07/03/2022
Initial Date OCFS Notified: 07/05/2022

Presenting Information

The Administration for Children's Services (ACS) completed an OCFS-7065 Agency Reporting Form on 7/5/22, after learning of the 6-day-old male subject child's death.

Executive Summary

On 7/3/22, ACS was notified by the hospital that the subject child passed away on the same date having never left the hospital. ACS had an open CPS investigation at the time, which was initiated on 6/27/22, the day after the subject child was born. The CPS report alleged there was not an appropriate caregiver for the subject child as the parents had three other children removed from their care and two of those children remained in foster care at the time of the subject child's birth. The father of the subject child was involved but reportedly did not reside in the home and was uncooperative with ACS. The investigation revealed there were two active stay away orders of protection against the father for the mother. The family was known to ACS as there was an open investigation at the time of the subject child's death as well as an open foster care services case regarding the two siblings, a third sibling died while in foster care in 2018.

The subject child was born via cesarean section at 32 weeks gestation and had multiple diagnoses, including prematurity. The record revealed that the mother had a history of high-risk pregnancies, including four preterm births. One of the pregnancies resulted in a stillbirth. The mother was compliant with prenatal care, and at the time of the subject child's birth, he was reported to be "relatively healthy" by medical personnel. The child remained in the NICU, receiving oxygen and required a feeding tube.

ACS investigated the circumstances surrounding the subject child's death and they learned that on 7/2/22 around 4:30PM, the subject child went into respiratory distress and was transferred to another hospital to receive intensive care. The subject child was unstable upon admission and his heart rate had dipped critically low. The subject child was placed on a ventilator and given medication to stabilize him. At approximately 6:00AM on 7/3/22, the subject child's heart rate dropped significantly and efforts to increase the heart rate were unsuccessful. The mother previously signed a DNR, thus resuscitation efforts were discontinued, and the subject child was pronounced deceased at 7:54AM.

An autopsy was completed and listed the cause of death as septic shock due to Escherichia Coli in the setting of prematurity. Due to the conditions surrounding the death, law enforcement was not involved.

The investigation open at the time of the fatality was unfounded on 8/12/22. The Family Services Stage (FSS) open at the time of the death remained open to provide additional foster care services and support to the family. The mother and father were referred for mental health counseling and bereavement services but declined referrals. The parents had no other children in their care as the siblings remained in foster care.

PIP Requirement
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The death of the subject child was not reported to the SCR, therefore, safety assessments and a determination were not required.

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:
Based on the information ACS gathered, they determined there was no reasonable cause to suspect the death was a result of abuse or maltreatment. Upon completion of case objectives, ACS closed the investigation that was open at the time of the fatality.

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: 07/03/2022 **Time of Death:** 07:54 AM

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

County where fatality incident occurred: New York
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 alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant

☐ Playing ☐ Eating ☐ Unknown
☒ Other: hospitalized

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	No Role	Male	6 Day(s)
Deceased Child's Household	Mother	No Role	Female	20 Year(s)
Other Household 1	Father	No Role	Male	21 Year(s)
Other Household 2	Sibling	No Role	Male	3 Year(s)
Other Household 3	Sibling	No Role	Male	1 Year(s)

LDSS Response

On 7/3/22, ACS was notified by hospital staff that the subject child had passed away on the same date. Upon being notified of the subject child's death, ACS notified the New York City Regional Office and submitted the required 7065 Agency Reporting Form. ACS spoke to providers and all relevant collateral sources. ACS assessed the safety of the siblings, ages 1 and 3-years and found them to be safe with their respective caregivers. During the time ACS was involved, the paternal grandmother petitioned the court and was awarded kin-gap custody of the siblings. They were assessed by ACS to be safe in her care.

Through interviews with medical personnel, it was learned the subject child was born prematurely and had multiple medical complications at birth. The child was admitted to the NICU following birth, where he received medical interventions related to respiratory complications. It was learned that, despite the mother's history of substance misuse and a sibling being born with a positive toxicology, screenings were not conducted to determine prenatal drug exposure. On 7/2/22, the subject child's health rapidly declined, and he was transferred to a different hospital where life-saving interventions were performed. Ultimately, the child succumbed to medical complications and was pronounced dead.

Hospital records and the postmortem medical examination confirmed the subject child passed away due to prematurity and complications during birth and not due to abuse or maltreatment by the mother or father.

Following the child's death, the parents became noncompliant with ACS and refused requests for in person communication. Phone calls to the parents were terminated and unannounced home visit attempts were not successful. ACS mailed out resources related to mental health, bereavement counseling, and burial assistance.

Throughout the investigation, ACS consulted with their legal department on separate occasions due to the parents' noncompliance, significant CPS history, and ongoing concerns. The older siblings remained in foster care due to intimate partner violence between the parents, substance misuse, and the mother's untreated mental health. Additionally, the parents continued to be noncompliant with the foster care agency personnel and their court orders.

Official Manner and Cause of Death

Official Manner: Natural

Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
This was not an SCR reported fatality. ACS spoke with relevant collateral sources and gathered information to determine the death was not the result of abuse or neglect.

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?				
Explain: The death of the subject child was not reported to the SCR, therefore, safety assessments and a determination were not required.				

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 siblings were remanded to foster care prior to the birth of the subject child and were receiving services unrelated to the fatality. The siblings were deemed safe in the care of their respective caregivers. ACS offered fatality-related services to the mother and father.				

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?	☐	☒	☐	☐
Explain as necessary: The siblings were placed in foster care prior to the subject child's birth.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

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:
ACS offered fatality-related services to the mother and father following the death. Foster care services were already being provided as the siblings had been in care prior to the birth of the subject child. The mother and father were ordered to complete services related to domestic violence and substance abuse, though they were not compliant with the conditions of their orders.

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 siblings were receiving foster care services. Due to their ages and cognitive development, fatality-related services were not deemed necessary.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided resources on burial assistance, bereavement services, and mental health counseling. The parents declined services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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? Yes
Was the child acutely ill during the two weeks before death? Yes

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 neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
06/27/2022	Deceased Child, Male, 1 Days	Mother, Female, 20 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
ACS received a report from the SCR alleging the mother gave birth to the subject child and had two other children removed from her care due to domestic violence.

Report Determination: Unfounded **Date of Determination:** 08/12/2022

Basis for Determination:
ACS' determination was irrelevant to what was alleged in the SCR report. ACS documented their determination was based on the child's death being the result of medical complications and not abuse or maltreatment.

OCFS Review Results:
ACS consulted their legal department and documented supervisory consultation throughout the investigation. Because death was not expected for the child, ACS and their legal department were in the process of filing removal paperwork for the child as he would not have been safe in the care of his parents.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS and their legal department determined the mother was incapable of being an adequate guardian for the subject child due to her history of DV and substance misuse, failure to adhere to court-ordered interventions, and her inability to care

for the two eldest siblings whose continuation in foster care was necessary for their safety. Despite this information, ACS unsubstantiated IG.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult their Regional Office if further guidance is needed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/09/2021	Sibling, Male, 1 Days	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 1 Days	Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:

ACS received a report from the SCR which alleged that on 5/8/21, the mother gave birth to the sibling at 32 weeks gestation. Upon birth, the mother tested positive for marijuana and the toxicology for the sibling was pending.

Report Determination: Indicated **Date of Determination:** 07/08/2021

Basis for Determination:

ACS determined there was credible evidence to substantiate IG and PDAM against the mother regarding the sibling. The sibling was born premature and medical records revealed the sibling was negatively impacted by the mother's substance misuse. The sibling had respiratory issues at birth and remained in the hospital for more than a month due to medical complications. A remand was granted by family court and the sibling was placed in non-kinship foster care. Ultimately, the sibling was released to the paternal grandmother against the recommendation of ACS.

OCFS Review Results:

ACS completed assessments within the required timeframes. The record contained supervisory and legal consultation. The progress notes clearly outlined why removal of the sibling was in his best interest and how continuation in the home would cause serious risk of harm. ACS did not document a completed Plan of Safe Care despite the mother testing positive for marijuana at the time of the sibling's birth.

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

Issue:

Failure to complete, document, and monitor a Plan of Safe Care

Summary:

ACS failed to develop, document & monitor a Plan of Safe Care to address the health and substance use disorder treatment needs of both the infant and affected caregiver despite knowledge the infant was identified as being born exposed to substances and documentation that the mother's substance misuse negatively impacted the sibling and caused medical complications.

Legal Reference:

17-OCFS-LCM-03 & 18-OCFS-LCM-06

Action:

ACS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. LDSS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

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

In 2018, the mother was named as a subject in two indicated reports with a common allegation of Inadequate

Guardianship. During that time period, two siblings were removed from the mother's care and placed in foster care.

On 6/15/18, ACS received a report from the SCR regarding the eldest sibling's death while in a certified foster boarding home. The allegations of DOA/Fatality and Inadequate Guardianship were unsubstantiated and the investigation was closed on 8/17/18. It was determined the sibling died as a result of SUID and the death was not the result of abuse or neglect by the foster parent.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Foster Care Placement History

The mother was considered a foster child at the time of the subject child's death as she was under the age of 21 and had not been freed for adoption, though she lived on her own. An FSS was opened on 1/5/18 and remained open at the time of this writing. During the time the FSS was open, the mother gave birth to the three siblings. The eldest sibling died in care on 6/15/18 and that child's cause of death was determined to be SIDS. The FSS was initially opened as the mother went AWOL from her mother/child program and left the sibling in the care of shelter staff. ACS filed an Article 10 neglect petition against the mother regarding the sibling who is now deceased. The sibling was remanded to a non-kinship foster home where he remained until his death. Another sibling was born on 9/13/18 and a derivative neglect petition was filed, and that sibling was remanded to a non-kinship foster home. On 5/8/21, the mother gave birth to the third sibling and derivative neglect was again filed and that sibling was placed in a non-kinship foster home but released to the PGM with court-ordered services. The 3 and 1-year-old siblings remained in care at the time of this writing. The mother and father failed to complete court-ordered services and were noncompliant with ACS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
Unknown	Adjudicated Neglected	Care/Custody to OCFS Commissioner
Respondent:	062009 Mother Female 20 Year(s)	
Comments:	An Article 10 neglect petition was filed against the mother regarding the eldest sibling and the child was remanded to foster care.	

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: The record reflected there was an Order of Protection barring the father from having contact with the mother due to ongoing physical domestic violence with the father acting as the perpetrator. The timeframe of the Order of Protection was not documented in the case record.	

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