Child Fatality Report

Report Identification Number: NY-22-049

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

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: 1 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 06/25/2022
Initial Date OCFS Notified: 06/26/2022

Presenting Information

The SCR report alleged on 6/25/22, the mother and father arrived at the hospital with the 1-month-old subject child who was unresponsive. The hospital staff performed CPR on the subject child but she was pronounced deceased at the hospital at 11:30PM. The subject child had no visible injuries. The subject child was born premature but was considered an otherwise healthy child. The mother and father did not have an explanation for the subject child's death. A subsequent report was received on 7/1/22 that alleged there had been domestic violence perpetrated by the father in which he kicked the mother in the stomach while she was pregnant.

Executive Summary

This fatality report concerns the death of a 1-month-old female subject child that occurred on 6/25/22. The SCR report contained allegations of Inadequate Guardianship and DOA/Fatality against the mother and father of the subject child. A subsequent report was received on the same date with additional allegations of Lack of Medical care against the mother and father. At the time of her death, the subject child resided in a domestic violence shelter with her mother, 2-year-old sibling, and 4-year-old sibling. The father of the subject child resided in a separate shelter. The 1-year-old sibling was residing out of state with a relative at the time of the fatality. The whereabouts of the siblings' fathers were unknown.

New York City Administration for Children's Services (ACS) completed collateral and casework contacts and learned that on 6/25/22 the mother, father, 2 and 4-year-old siblings were traveling back from North Carolina on a bus. The subject child was riding in her car seat for the duration of the bus trip and was fed two ounces of formula at 4:00PM. Around 8:00PM the parents attempted to feed the subject child again but, she ate less than one ounce, only briefly opened her eyes, and was not moving. The parents arrived at their destination around 10:30PM and immediately went to the hospital after leaving the bus, as both noted something was wrong with the subject child since she would no longer open her eyes. The mother and father reported the subject child had a heartbeat upon arrival to the hospital; however, hospital staff stated she was pulseless and unresponsive. Hospital staff attempted life-saving measures for approximately 30 minutes before pronouncing the subject child deceased.

An autopsy was performed, and the final cause and manner of death were pending at the time of case closure. The medical examiner noted no signs or trauma or abuse, and stated the preliminary findings indicated the subject child's death was related to a viral infection, as the subject child tested positive for Respiratory Syncytial Virus (RSV) and Rhinovirus. No arrests were made in relation to the subject child's death and law enforcement did not find evidence of criminality; however, law enforcement reported the mother and father acted negligently by traveling with the child on a bus after her recent discharge from the hospital. The hospital physician reported that it would have been against medical advice to travel with the subject child due to her recent hospitalization, age and the duration of time she would be required to be in a car seat. The parents did not follow-up with medical appointments for the subject child prior to traveling out of state and failed to seek immediate medical attention when they observed the subject child in medical distress on the bus. After repeated medical neglect, the subject child died due to medical complications.

The family was offered bereavement services following the subject child's death. A Neglect Petition was filed against the father during the investigation due to a history of domestic violence perpetrated against the mother in the presence of the children. A preventive service case was opened following the fatality to provide additional support to the mother. The 2 and 4-year-old sibling were deemed safe with the mother and remained in her care. The 1-year-old sibling remained in North Carolina with a relative for the duration of the investigation. The allegations were substantiated against the mother

and father due to ACS finding a fair preponderance of evidence to support that the delay in seeking medical attention when the subject child was in distress may have contributed to her demise. The report was indicated and closed on 8/24/22.

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:**
  - **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:
While ACS made an appropriate determination based on evidence obtained throughout the investigation; two fatality reports were investigated concurrently but the allegation of LMC was only listed and substantiated for the subsequent fatality report and not the initial, despite information being the same in both cases.

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 record did not reflect attempts to locate or interview the BF of the 4yo SS despite him being identified and added to the case composition.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegation of LMC was not added and substantiated in the initial report. The parents knew the child was in medical distress and they delayed seeking medical treatment.
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 with the NYC Regional Office if further guidance is needed.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The record did not reflect attempts to locate or interview the BF of the 4yo SS despite him being identified and added to the case composition.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/25/2022 **Time of Death:** 11:30 PM

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? 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	Female	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)

Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	24 Year(s)
Other Household 2	Other Adult - Mother's Godfather	No Role	Male	48 Year(s)
Other Household 2	Sibling	No Role	Female	1 Year(s)
Other Household 3	Other Adult - Father of 4yo SS	No Role	Male	23 Year(s)
Other Household 4	Other Adult - Father of 2yo SS	No Role	Male	23 Year(s)
Other Household 5	Other Adult - Father of 1yo SS	No Role	Male	23 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their investigation with law enforcement, spoke with collateral sources, conducted interviews with the parents and SSs, and offered services regarding the fatality.

ACS interviewed the SM and SF together and learned that on 6/18/22 the SM, SF, SC, 2yo SS, and 4yo SS traveled to NC to visit the MGM who was ill. The SC was noted to have had a stuffy nose, cough, and runny nose the day prior to her death, and the SSs also had cold symptoms. On 6/25/22 the family departed NC on a bus to return to NYS. The SM fed the SC 2 ounces of formula and the SC then slept in her car seat. Around 8:00PM, the SM attempted to feed the SC again; however, she ate less than 1 ounce of formula at that time. The SM reported the SC was breathing, but barely opened her eyes and was not moving. The SF reported the SC's face was cold, but noted the AC was on in the bus. The SM reported feeling the SC's heartbeat and the SF reported feeling the SC's pulse. The SF described the SC's breathing as rapid and fainter than normal. After getting off the bus around 10:30PM, the SM and SF brought the SC to the hospital. The hospital physician reported the SC was pulseless and not breathing upon arrival, and while they could not definitively say what time the SC became unresponsive, they estimated the SC was deceased between 8:00-10:00PM. Life-saving measures were attempted by hospital staff but were unsuccessful and the SC was pronounced deceased at 11:30PM. The SM and SF stated they did not seek medical attention until after getting off the bus, as they had felt the SC's heartbeat and observed her breathing.

The SC was born premature at 29 weeks gestation and was in the Neonatal Intensive Care Unit (NICU) for approximately 4 weeks. The SC had RSV while in the NICU and the hospital stated this could have contributed to her death. The SM reported the SC was also born with a hole in her heart that would possibly need surgery in the future but was advised by doctors that it was not a concern at the time.

The SM reported that she received permission to travel with the SC at the time of her discharge from the NICU on 6/16/22; however, ACS spoke to multiple hospital staff who denied the SM inquiring about traveling and stated it would have been advised that the SM not travel with a child under 2 months and a child of that age should not be in a car seat for that duration of time. The SM was directed by hospital staff at the time of the SC's discharge from the NICU to follow up with numerous medical appointments for newborn care, tachycardia which the SC had at birth, vision services, and the NICU. Hospital staff reported the SM did not follow up with any appointments besides the NICU, though the SM reported seeing the doctor about newborn care the day after discharge and the doctor noted no concerns.

At the time of case closure, the SM and SSs continued to reside in a domestic violence shelter with an OOP against the SF. The SF had no visitation or contact with the SSs, as he was not their father. In addition to bereavement services, the SM was recommended for MH, parenting, and medical services. The SF was recommended to complete a substance use evaluation as there were concerns about alcohol misuse while caring for the children, as well as a domestic violence perpetrator program. The preventive services case remained open at the time of this writing.

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: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061962 - Deceased Child, Female, 1 Mons	061963 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
061962 - Deceased Child, Female, 1 Mons	061963 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
061962 - Deceased Child, Female, 1 Mons	061964 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated
061962 - Deceased Child, Female, 1 Mons	061964 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
061967 - Sibling, Male, 4 Year(s)	061963 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
061967 - Sibling, Male, 4 Year(s)	061964 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
061968 - Sibling, Female, 2 Year(s)	061963 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
061968 - Sibling, Female, 2 Year(s)	061964 - Father, Male, 24 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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:

A death-scene investigation was not completed due to the SC becoming unresponsive on a bus. The record did not reflect attempts to interview the father of the 4yo SS despite being identified and added to the case composition.

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 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?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/30/2022	There was not a fact finding	There was not a disposition
Respondent:	061964 Father Male 24 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against the father due to the history of domestic violence perpetrated against the mother and in the presence of the children. A stay away order of protection was filed against the father, protecting the mother and children. The children were released to the mother on the condition she follow through with mental health, parenting, bereavement, and medical services.	

Have any Orders of Protection been issued? Yes	
From: 06/30/2022	**To:** Unknown
Explain: An Order of Protection was issued following ACS filing an Article 10 against the father protecting the mother and children.	

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:
As a result of ACS filing an Article 10 against the father, the mother was recommended to engage with parenting classes, mental health, bereavement and medical services. The father was recommended to complete a substance use evaluation, bereavement, and domestic violence services.

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:
Services were offered on behalf of the surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services and funeral assistance were offered to the family in response to the fatality. Preventive services were also opened following the SC's death on 6/28/22 and remain open.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? Yes

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☒ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☐ 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

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

The family relocated to NYS from North Carolina. The mother and father have CPS history in NC due to concerns of domestic violence, conditions/stability of housing, the 2yo SS ingesting the father's prescribed medication, mental health, dental conditions, the father being physical with the 4yo SS, and the children obtaining injuries. Relatives reported additional allegations of the mother burning the children with a cigarette were investigated by CPS in NC.

Preventive Services History

A preventive services case was opened following the death of the SC to provide additional support to the SM and remained open at the time of this writing.

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