Child Fatality Report

Report Identification Number: NY-22-073

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

Issue Date: Jan 24, 2023

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 **Jurisdiction:** Kings **Date of Death:** 09/08/2022
Age: 24 day(s) **Gender:** Male **Initial Date OCFS Notified:** 09/08/2022

Presenting Information

The Administration for Children's Services (ACS) received an SCR report on 9/8/22, which alleged the mother breastfed the 24-day-old subject child after she got out of the shower. The child would not suckle during the feeding. The mother placed the child on a bed and went to the bathroom to get dressed. When the mother returned from the bathroom, the child appeared yellow in color. The mother called 911 and began CPR. The twin to the subject child was in a bassinet. EMS arrived and continued CPR. The mother, subject child, and twin sibling were transported to the hospital. The subject child was pronounced deceased at 4:00PM. The child was otherwise healthy, and the mother had no explanation for his death. The surviving twin and father had unknown roles.

Executive Summary

This report concerns the death of the 24-day-old subject child. ACS received an SCR report regarding the child's death on 9/8/22. At the time of the child's death, he resided with his mother and twin sibling.

Since their birth on 8/15/22, and until 9/1/22, the mother fed the subject child and twin sibling a combination of formula and breastmilk. The mother ran out of formula on 9/1/22 and subsequently nursed exclusively. The mother began to notice signs of weight loss on the subject child in that she observed frown lines on his face. The mother ordered additional formula which did not arrive prior to the fatal incident. On 9/8/22, at 2:00PM, the mother attempted to breastfeed the subject child; however, he would not latch. The mother called a friend, who advised her to call the pediatrician. The mother had not yet established the children at a pediatric office and was advised to call 911. Prior to calling 911, the mother took a shower and got dressed. Upon observing the subject child after the shower, the mother noticed he was yellow in color and appeared limp. The mother then called 911 and was directed to perform CPR. EMS responded to the home, took over CPR, and transported the child to the hospital. The subject child did not respond to treatment and was pronounced dead at 4:00PM.

The medical examiner was notified and performed an autopsy of the child. The cause and manner of death were pending at the time this report was written. Law enforcement investigated, and no arrest had been made. No signs of injury to the child were noted.

ACS made several home visits and interviewed the mother. The twin sibling was assessed to be in immediate and impending danger and ACS removed the sibling on 9/8/22. The sibling was medically evaluated and admitted to the hospital on 9/8/22 due to dehydration, jaundice, and failure to thrive. The sibling was discharged from the hospital on 9/16/22 and entered foster care. The sibling was returned to the mother's care on 10/3/22 by the family court judge over ACS objections with court ordered supervision.

ACS substantiated all allegations against the mother regarding the subject child and sibling. ACS determined the mother was responsible for the care, safety, and well-being of the subject child and sibling and failed to protect the children and failed to provide a minimum degree of care to either child. The mother failed to provide the children with adequate food and nutritional intake, resulting in noticeable weight loss in the infants. The subject child went from 4.02lbs to 3lbs and the sibling went from 5.45lbs to 4lbs prior to any medical intervention being sought and were described as "emaciated." The mother observed frown lines on the subject child and failed to seek medical attention and failed to provide supplemental formula for one week. ACS determined the mother's lack of action resulted in the subject child's death. Additionally, the sibling was diagnosed failure to thrive, dehydrated and jaundiced due to lack of adequate nutritional

intake. Despite a discharge plan from the birthing hospital to follow-up with a pediatrician for both children within 1 to 3 days, the mother failed to make the appointment which resulted in neither child receiving medical treatment until they were in distress.

Due to court ordered supervision, a CPS services case was opened with the family. The mother was engaged in bereavement services and working toward service plan goals at the time this report was written.

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

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:
Due to court ordered services, the case was opened for PPRS following the conclusion of the fatality investigation.

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: 09/08/2022 **Time of Death:** 04:00 PM

Time of fatal incident, if different than time of death: 02:00 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 02:49 PM
Did EMS respond to the scene? Yes
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	Male	24 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	24 Day(s)
Other Household 1	Father	No Role	Male	45 Year(s)

LDSS Response

On 9/8/22, ACS received an SCR report regarding the death of SC. ACS initiated their investigation within 24 hours and contacted the source of the report. A CPS history check was completed, and the DA was informed of the fatality. ACS assessed the safety of the SS, which resulted in an Article 10 Neglect Petition being filed and the remand of SS to ACS on 9/8/22.

ACS interviewed SM at the hospital. SM combination fed SC and SS upon discharge from the hospital, until she ran out of formula on 9/1/22, at which point SM exclusively breastfed. SM was unaware of how much milk she produced as she did not have a breast pump and never expressed milk. SM was asked if she had any concerns for SC or SS and she said in the three days prior to the fatal event neither infant had moved their bowels. SM said she was under the impression breastfed babies did not move their bowels daily. Additionally, SM felt both SC and SS were losing weight, which was noticeable in SC in that SM said she could see frown lines on SC's face. SM stated she did not seek medical attention at that time; however, ordered supplemental formula which did not arrive until after SC's death. ACS asked about the 24 hours leading up to SC's death. The night before, SC was crying more often. SM nursed SC on 9/8/22 at 4:00AM, 7:43AM, 9:00AM, 10:46AM, 12:00PM and again at 2:00PM. At the 2:00PM feeding, SC would not latch. SM called her friend who instructed her to call the pediatrician. SM called the pediatrician; however, SC and SS were not established patients at the practice and SM was advised to call 911. SM stated she knew she had to take SC to the hospital, so she took a quick shower, and upon returning to the bedroom she noticed SC was yellow in color, limp, and his limbs hung. SM called 911 and followed 911 operator instructions to perform CPR. EMS arrived and took over CPR and transported SC to the

hospital. SM and SS were transported by NYPD. SC arrived at the hospital at 3:28PM and CPR continued. SC did not respond and was pronounced dead at 4:00PM. Hospital staff did not observe any marks or bruises on SC.

Upon observing SC, doctors examined SS and SS was admitted to the hospital on 9/8/22. SS was diagnosed failure to thrive and dehydrated due to low intake and poor feeding, as well as jaundice due to the dehydration. Doctors expressed SC presented with similar symptoms and believed SC's death was due to inadequate intake of nutrition. SC and SS were described as "emaciated" by doctors. SC had a birth weight of 4.02lbs and weighed 3lbs at the time of his death. SS had a birth weight of 5.45lbs and weighed 4lbs upon admission to the hospital. SS was discharged 9/16/22 to a foster home and it was noted SS displayed no difficulty feeding.

ACS contacted numerous collaterals, including LE, medical staff, the ME, and accessed family court. ACS spoke with the alleged BF, who denied the CHN were his and indicated SM had a history of alcohol and substance misuse. ACS addressed the concerns with SM. ACS learned following the birth of SC and SS, SM was referred to a pediatrician and was expected to schedule a follow-up appointment in 1 to 3 days. This appointment was never scheduled, and SM did not call to schedule an appointment until 9/8/22, the day of the fatal event, which was subsequently scheduled for 9/13/22.

ACS spoke with the ME, who reported the cause and manner of death were pending and results would take 3 to 4 months.

Over ACS objection, SS was returned to SM's custody by the family court judge on 10/3/22. Special medical preventive services were put in place and SM was engaged with services at the time this fatality report was written. The record reflected Visiting Nurse Services and the SS's pediatrician indicated the SS was gaining weight appropriately and was most recently seen 1/5/23. ACS found a fair preponderance of evidence to support the allegations and indicated the investigation.

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 area does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061521 - Deceased Child, Male, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	DOA / Fatality	Substantiated
061521 - Deceased Child, Male, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061521 - Deceased Child, Male, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	Inadequate Guardianship	Substantiated
061521 - Deceased Child, Male, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	Lack of Medical Care	Substantiated

061541 - Sibling, Female, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061541 - Sibling, Female, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	Inadequate Guardianship	Substantiated
061541 - Sibling, Female, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	Lack of Medical Care	Substantiated
061541 - Sibling, Female, 24 Day(s)	061542 - Mother, Female, 44 Year(s)	Malnutrition / Failure to Thrive	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:

ACS attempted to speak with EMS to no avail. There was no legally established father for the CHN; however, ACS attempted to interview the alleged father. He declined to be interviewed face-to-face. The CHN had no established pediatrician.

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	☒	☐	☐	☐

Explain:
As a result of family court intervention, court ordered services were implemented. The mother was engaged in bereavement counseling prior to the case closing and had a service plan to engage in a mental health assessment, parenting skills, visiting nurse services, and a substance use evaluation.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
An emergency removal of the surviving sibling was done on 9/8/22. A Neglect Petition was filed in family court on 9/9/22 and the removal was upheld. The sibling remained hospitalized 9/8/22 until 9/16/22, at which point she was discharged to a foster home. Following a 1028 hearing in family court, the sibling was returned to the mother's care on 10/3/22 with court ordered supervision.

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:**
09/09/2022	There was not a fact finding	There was not a disposition
Respondent:	061542 Mother Female 44 Year(s)	
Comments:	An emergency removal was conducted of the surviving sibling on 9/8/22 and ACS filed a Neglect Petition against the mother on 9/9/22, requesting the removal of the surviving sibling. The removal was granted and the sibling was remanded to ACS custody on 9/9/22. On 9/14/22, the mother requested a 1028 hearing. On 10/3/22, following multiple days of testimony, the Judge granted the mother's request for the sibling to return home over ACS's objection. Orders were put in place to mitigate risk and the sibling was released to the mother with court ordered supervision. The mother was ordered to comply with preventive services, comply with a visiting nurse service, attend all medical appointments, participate in a parenting skills class, participate in bereavement counseling, and sign releases of information to confirm compliance with orders. At a 10/11/22 court appearance, ACS noted no concerns since the sibling's return to the mother's care and service referrals had been made. A settlement conference was scheduled for 12/14/22.	

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: PPRS							

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?	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 neither 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 was no known 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