Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-111

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

Issue Date: Apr 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 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: 16 day(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 11/14/2022
Initial Date OCFS Notified: 12/29/2022

Presenting Information

A completed OCFS-7065 Agency Reporting Form was received regarding the death of the 16-day-old subject child who was involved in an open CPS investigation. The form reflected that the subject child was born prematurely on 10/29/22, with several health complications including low birth weight, a positive toxicology with substance withdrawal, as well as a cardiac condition. The child remained in the hospital since his birth and passed away on 11/14/22 at 6:30PM due to complications associated with his heart condition.

Executive Summary

This fatality report concerns the death of the 16-day-old male subject child that occurred on 11/14/22. ACS was made aware on 11/22/22 that the subject child died while in the neonatal intensive care unit, where he had been since his birth. The fatality occurred during an open CPS investigation, which was received on 10/31/22, following the subject child's birth. There were no surviving siblings.

On 10/29/22, the mother went to the hospital for pain, and it was discovered she was in labor. The mother believed she was early in the stages of pregnancy and had a termination scheduled for 10/31/22; however, the mother was approximately 33 weeks into the pregnancy. The child was born prematurely, positive for cocaine, experiencing withdrawal, and underweight. The child was admitted to the neonatal intensive care unit. Around 11/4/22, the subject child was transported to a second hospital due to respiratory distress. The child began decompensating upon arrival and despite interventions, the child's health continued to decline. The child passed away 11/14/22 due to a congenital heart defect.

An autopsy was not performed, and the death was not referred to a medical examiner as it was determined the child died due to natural causes.

ACS made several attempts to engage the parents in service planning following the fatality; however, despite their original receptiveness and cooperation with ACS, they ultimately stopped responding to ACS's outreaches. The record reflected they were provided community-based organization referrals; however, it was unknown if they engaged in any services following the fatality. The record did not reflect if the mother was specifically provided substance use referrals, as recommended by the Credentialed Alcoholism and Substance Abuse Counselor consultation held on 11/7/22.

PIP Requirement
For citations identified in historical cases, ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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:
This was not an SCR reported fatality, therefore a determination was not required. Additionally, as there were no surviving siblings, safety assessments were not required.

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:
Casework was commensurate with case circumstances. Attempts were made to engage the parents in a family team meeting to assess service needs; however, the parents ultimately did not make themselves available to ACS following the fatality. As there was no service need identified and no surviving children, the case was appropriately closed.

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: 11/14/2022 **Time of Death:** 06:30 PM

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 and/or ingested alcohol or drugs? N/A

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	16 Day(s)
Deceased Child's Household	Father	No Role	Male	28 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)

LDSS Response

At the time of the fatality, the family was involved in an active CPS investigation, initiated on 10/31/22. The investigation was regarding the mother giving birth to the subject child, and both the mother and child testing positive for substances, as well as the mother not having appropriate provisions for the child. The child was born at approximately 33 weeks gestation and positive for cocaine. The child was underweight, experienced withdrawal symptoms, and required supplemental oxygen. The child was admitted to the neonatal intensive care unit.

ACS learned of the subject child's death on 11/22/22. The subject child passed away 11/14/22 while hospitalized.

ACS interviewed the parents. The mother learned of her pregnancy with the subject child around mid-August 2022 after numerous negative pregnancy tests. The mother believed she was approximately eight weeks pregnant and intended to terminate the pregnancy. The mother used cocaine prior to the confirmed pregnancy, as well as once after, on or around 10/27/22, as the termination was scheduled for 10/31/22. Additionally, the mother consumed alcohol during the pregnancy. The mother denied any other substance use. The mother went into spontaneous labor on 10/29/22, and an ultrasound showed she was approximately 33 weeks along in the pregnancy. The mother believed she was unable to conceive, and expressed had she known, she "would have made better choices." The father confirmed the mother's account of learning of the pregnancy in mid-August, knowing of her cocaine use, and the scheduled termination. Both the mother and father expressed their intent to do whatever was needed to ensure the child's well-being now that he was born.

ACS communicated with medical staff regarding the subject child's treatment and prognosis. The child was born at approximately 33 weeks and weighed 3.9 pounds. It was originally expected the child would require three to six weeks in the hospital to become medically stable. Around 11/4/22, the child was transferred to a second hospital for a higher level of care due to respiratory distress. The child decompensated upon arrival to the second hospital due to lack of oxygen, respiratory failure, shock, and multi-organ dysfunction. Despite receiving the maximum allotment of medications, the child's heart rate and blood pressure continued trending down. The child presented with progressive necrotic appearance to his arms and chest, and it was predicted he would not make it through the evening of 11/15/22. The parents were informed by the hospital and the child passed away in the mother's arms on 11/14/22 around 6:30PM.

Medical staff reported there was no connection between the mother's substance use or lack of prenatal care and the child's death. The child was born with an interrupted aortic arch and died from a congenital heart defect. The death was not referred to the medical examiner as the child died of natural causes.

The parents initially expressed interest in bereavement and support services following the fatality. ACS made numerous outreaches to the parents separately; however, they become unresponsive. It was unknown if the parents engaged in any services. Due to the parents' unwillingness to further engage with ACS and there being no surviving children in the household, the case was closed.

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: Hospital physician

Multidisciplinary Investigation/Review

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.

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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral

Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☒	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered bereavement services and a family team meeting was scheduled to assess for any further service needs in response to the fatality; however, the parents ultimately did not make themselves available to ACS following the fatality.

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? N/A
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
- ☒ 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/31/2022	Deceased Child, Male, 2 Days	Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 2 Days	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Days	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
ACS received a report on 10/29/22, which alleged the mother gave birth to the subject child and the mother and child tested positive for cocaine at the time of delivery. Until August 2022, the mother used cocaine, MDMA, mushrooms, and consumed alcohol. As a result, the child was experiencing withdrawal symptoms, required supplimental oxygen, and was underweight. Additionally, the mother did not have the necessities for the child; including food, clothing, a safe sleep environment, and other items.

Report Determination: Unfounded | **Date of Determination:** 12/27/2022

Basis for Determination:
ACS unsubstantiated all allegations against the mother regarding the subject child. ACS determined the mother was unaware of her pregnancy and how far along in the pregnancy she was. Although the mother engaged in substance use, she was unaware of the pregnancy and upon learning of the pregnancy, the mother scheduled a termination. The mother never intended to have the child; however, went into sudden labor prior to her scheduled termination appointment. The child never left the hospital prior to his death.

OCFS Review Results:
ACS initiated their investigation timely, interviewed the parents separately, observed the subject child in the hospital, and made appropriate collateral contacts with hospital staff. ACS attempted to further engage the parents after the subject child's passing; however, the parents did not make themselves available to ACS. The allegations were unsubstantiated, and the case was appropriately closed as there were no other children in the care of either parent and the parents were no longer responsive to ACS's outreaches. The required OCFS-7065 Agency Reporting Form was completed untimely and the appropriate Regional Office was notified of the death untimely.

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

Issue:
Child's death not reported to the RO in a timely manner

Summary:
ACS learned of the subject child's death while their investigation was open, on 11/22/22. Though required to notify the Regional Office within 24 hours, ACS did not notify them until 12/1/22.
Legal Reference:
18 NYCRR 441.7(c)
Action:
All authorized agencies must report to the Regional Office the death of a child involved in an open protective or preventive case within 24 hours of death or as soon thereafter as the agency becomes aware of the death.

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