Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-020

Prepared by: New York City Regional Office

Issue Date: Aug 12, 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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 26 day(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 02/19/2022
Initial Date OCFS Notified: 03/28/2022

Presenting Information

On 2/22/2022, the New York City Administration for Children's Services (ACS) learned of the death of the 26-day-old male subject child that occurred on 2/19/22 due to a medical condition. The family had an open Child Protective Services case at the time of his death regarding the mother having other children who had been previously removed from her care. ACS notified the New York City Regional Office via the 7065 Agency Reporting Form.

Executive Summary

On 2/22/2022, ACS was notified by the hospital of the death of the 26-day-old male child that occurred on 2/19/2022. An attempt was made to report the death to the SCR but was not accepted, as there was no reason to suspect the death was a result of abuse or maltreatment by the parents and was rather the result of a medical condition. The mother had 3 minor children who had been removed from her care and resided in another state. The mother had no contact with these children.

Through contacts with the parents and medical providers, ACS learned that the child was born on 1/24/2022 and diagnosed with the genetic disorder trisomy 18 and a congenital heart defect. The mother was in receipt of prenatal care; however, the record did not reflect if the child was diagnosed with the disorder in utero or after the birth. The child was hospitalized in the neonatal intensive care unit with a poor chance of survival. The child was not discharged from the hospital during his life and died on 2/19/2022 as a result of his condition.

ACS requested a medical consultation to obtain information about the child's diagnosis and recommendations to support the family. Following the death, the family requested privacy from ACS and did not respond to further outreach to provide them with assistance. A mental health and domestic violence consultation request was submitted on 2/22/2022. The mother was referred for a substance use evaluation due to a history of substance misuse. It was unknown if the parents were enrolled in services regarding the fatality. The CPS investigation open at the time of the death was unfounded and closed on 3/25/2022.

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:
It was determined the child's death was not the result of maltreatment by the mother and father. The parents had no other children in their care and there was no need for ongoing services.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS gathered information surrounding the circumstances of the death, made efforts to offer appropriate services and closed the CPS 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: 02/19/2022 **Time of Death:** 01:03 AM

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

County where fatality incident occurred: Bronx
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: Hospitalized

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **At the hospital with the child**

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	26 Day(s)
Deceased Child's Household	Father	No Role	Male	44 Year(s)
Deceased Child's Household	Mother	No Role	Female	45 Year(s)

LDSS Response

After learning about the child's death, ACS notified OCFS through the required 7065 Agency Reporting Form, documented supervisory consultations, spoke to hospital staff and attempted contact with the parents.

Upon receipt of the SCR report at the time of the child's birth, ACS began gathering information regarding the child's medical condition. It was learned that the child was diagnosed with the genetic disorder trisomy 18 and a congenital heart defect. The child was admitted to the neonatal intensive care unit. ACS requested a medical consultation regarding the child's condition and the needs of the family. The medical consultant provided information regarding the diagnosis and prognosis, which included that that trisomy 18, also known as Edwards Syndrome, was a condition in which the child was born with an extra chromosome, which can result in heart defects and abnormalities of other organs. It was common for children with the diagnosis to die soon after birth due to complications. The medical consultant recommended ACS obtain additional information regarding the child's prognosis and the plan for his care. In addition, it was recommended the parents be provided with mental health support. ACS documented efforts to speak to the child's medical providers and coordinate contact between the medical consultant and physician.

On 2/18/2022, the child underwent surgery for his trachea being too narrow and the surgery was performed without complications. The child was using synchronized intermittent mandatory ventilation to help him breath and was intubated. On 2/22/2022, the hospital notified ACS that the child died due to his condition of trisomy 18. Due to death being a result of a medical condition, it was not documented that an autopsy was performed or that law enforcement was notified.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Prior to the death, ACS requested a substance use evaluation due to the mother's history of substance misuse and a medical consultation. In addition, they discussed housing assistance. Following the death, ACS made outreaches to the parents; however, they did not wish to speak with ACS. ACS completed a request for a domestic violence and mental health consultation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS contacted the parents following the death. The parents requested time to grieve before speaking with ACS. ACS attempted another phone call which was not successful.

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? Yes
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
☒ 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)
01/26/2022	Deceased Child, Male, 2 Days	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report received alleged that the mother gave birth to the subject child on 1/24/2022 and would be unable to care for the child because the mother had other children that were removed from her care due to abuse and neglect and had not been returned to her.

Report Determination: Unfounded	**Date of Determination:** 03/25/2022

Basis for Determination:
The allegation of Inadequate Guardianship against the mother regarding the subject child was unsubstantiated. The child was born with a genetic condition known as trisomy 18 and was never discharged from the hospital where he was declared deceased on 2/19/2022. There was no reason to suspect the parents caused or contributed to the death. The mother had appropriate provisions for the child and knew of community resources available for any additional needs of the family.

OCFS Review Results:
ACS contacted the source, interviewed the mother and father, and maintained contact with the hospital throughout the duration of the investigation. There were several supervisory consultations documented, in addition to a medical consultation. It was confirmed the mother had children removed from her care in the past, and those children resided in Vermont and had not been returned to the mother due to concerns of domestic violence, substance misuse and mental health. The mother submitted to a drug screen and was negative for all substances. The mother reported being in receipt of mental health treatment in the years prior and the parents reported no domestic violence in their relationship.

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

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 mother had indicated CPS History in Florida regarding her now adult children. In 2008, the children were placed in the custody of their father with a Order of Protection against the mother.

The mother had three minor children, a now 5-year-old and 10-year-old twins, who resided in Vermont and were not in her care. The 5-year old was removed from the mother at birth in 2016 due to the mother's mental health, substance misuse, violent behavior, and her refusal to participate in services and was referred for ongoing services. The documentation provided to ACS by Vermont Department for Children and Families did not reflect the current status of the 5-year-old sibling. The mother reported the father of the 5-year-old child lived in Vermont and the 5-year-old was in his custody. The mother reported she lost custody of the 10-year-old twins when they were 1, because of domestic violence. The twins have since been adopted. The mother reported she did not have any contact information for the siblings.

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