Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-041

Prepared by: New York City Regional Office

Issue Date: Nov 28, 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: 4 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 05/15/2022
Initial Date OCFS Notified: 06/03/2022

Presenting Information

The Administration for Children's Services (ACS) completed the 7065 Agency Reporting Form after learning of the four-month-old subject child's death; the form was not completed within the required timeframe. The form reported the subject child was born on 1/5/22 with numerous medical conditions, and remained hospitalized until her death on 5/15/22.

Executive Summary

This fatality report concerns the death of a four-month-old female subject child that occurred on 5/15/22. On 6/24/22, the New York City Administration for Children's Services (ACS) submitted a completed 7065 Reporting Form to OCFS which noted the subject child was hospitalized after her birth on 1/5/22 and remained so until the date of her death. The fatality occurred during an open voluntary preventive services case which was addressing the needs of the family, as the mother was a single parent with seven children, many of whom had special needs. It was noted in the case record that the subject child was born medically fragile; however, a cause and manner of death was not documented.

At the time of the subject child's death, she was hospitalized with no anticipated release date due to her ongoing medical concerns. There were six surviving siblings, ages 13, 12, 11, and seven years old, as well as two who were six years old. The record noted the mother would not provide information regarding the biological fathers of the children. It was learned that the voluntary services case planner received a call from the mother on 5/16/22 to report the subject child had died the night prior. The case record did not reflect any additional follow up questions were asked, nor was the hospital staff who had been caring for the child spoken with about the fatality. Further, a time of death was not noted.

The voluntary services case planner provided the mother with service referrals for grief and bereavement counseling for herself and the surviving siblings. The surviving siblings were deemed safe in the care of the mother, and the preventive services case remained open and ongoing at the time this report was issued.

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:
This was not an SCR reported fatality.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
Aside from requesting medical records, there was no documented follow up with the hospital staff who cared for SC regarding her cause/manner of death or any concerns they may have had. Additionally, the record did not reflect if the hospital staff who completed a mental health evaluation on the 11yo surviving sibling were spoken with regarding any treatment recommendations.

Required Actions Related to the Fatality

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:	The completed 7065 Reporting Form was not submitted to the regional office until 6/24/22.
Legal Reference:	18 NYCRR 441.7(c)
Action:	ACS is required to provide telephone notice to the Regional Office within 24 hours of the learning of the death of a child in an open CPS or preventive services case. Within 72 hours of the death, ACS must complete a copy of the 7065 Form and e-mail or fax it to the Regional Office, and to any approved local or regional fatality review team that will review the fatality.
Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	Following the death of the subject child, progress notes regarding service plan goals contain contradictory information and reflect the subject child is still alive.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS must provide a thorough family assessment and an account of all services delivered to children and their families through case records maintained in the form and manner and at such times as required by OCFS. Such records must contain information that is relevant, useful, factual and objective.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/15/2022 **Time of Death:** Unknown

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

County where fatality incident occurred: Richmond
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.

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	Female	4 Month(s)
Deceased Child's Household	Mother	No Role	Female	31 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)

LDSS Response

On 6/24/22, OCFS received the completed 7065 form regarding the death of SC, which occurred on 5/15/22. At the time of the fatality, the family had been involved in voluntary preventive services due to concerns BM was overwhelmed with caring for her seven children, many of whom had special needs. There were further concerns regarding BM's lack of stable housing for the CHN, lack of resources for the family, and her ability to cope with having a newborn medically fragile CH. As SC had never left the hospital after her birth, there was no reasonable cause to suspect her death was due to abuse or maltreatment, and an SCR report was not necessary.

On 5/16/22, BM contacted CP and informed her that SC died the previous night. On 5/17/22, CP spoke with the 11yo SS's school, and staff informed CP that SS was distraught over SC's death and made threats to self-harm. School staff explained mobile crisis was called to the school and SS was brought to the hospital. On this same date, CP spoke with BM via phone. BM explained SS was being evaluated, and the other SSs were okay. BM reported the 11yo SS was closer to SC than the other CHN. CP provided BM with resources for grief and bereavement counseling for herself and the SSs during this conversation; however, BM expressed wanting to utilize resources in her community that would provide services in her home. The 11yo SS was released from the hospital on 5/17/22. BM would not provide any information to CP regarding the outcome and reported she would not allow SS to be placed on any medication. The record did not reflect

any further follow up regarding the 11yo SS's evaluation or treatment recommendations.

The case record reflected CP made several requests for SC's medical records from the hospital where she was admitted to no avail. CP also asked BM to obtain the records as well as SC's death certificate. It was noted BM provided CP with the death certificate; however, no information regarding the cause and manner of death was recorded in the case record. The record did not reflect any further follow up with medical staff that cared for SC while she was alive, specifically regarding a cause of death or any concerns they may have had regarding BM or the SSs.

Following SC's death, CP assessed the safety of the SSs and continued to encourage BM to attend grief counseling. The needs of the family continued to be addressed through service plan goals and regular home visits. The SSs were deemed safe in the care of BM, and the voluntary preventive services case remained open and ongoing at the time this report was issued.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: From a medical cause
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
Comments: ACS 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:
The record did not reflect if the hospital staff who cared for SC were spoken with following the fatality.

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: This was not an SCR reported fatality investigation and safety assessments 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 11yo SS expressed thoughts of self-harm following the death of SC; however, the record did not reflect adequate follow up from the CP regarding this: The record did not reflect if ACS spoke with SS nor did it reflect if hospital staff were contacted regarding the mental health evaluation and the doctor's recommendations. The family was engaged in an open preventive services case at the time of the fatality.				

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: This was not an SCR reported fatality investigation.				

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Voluntary Preventive Services

Additional information, if necessary:
The family was engaged in a voluntary preventive services case at the time of the fatality. Grief and bereavement referrals were provided for the mother and siblings. The record did not reflect if family planning services were discussed.

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 family was involved in a preventive services case and the siblings were referred to grief counseling following the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was involved in a preventive services case and the mother was referred to grief counseling following the fatality.

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
- ☐ 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)
01/04/2022	Sibling, Female, 13 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Female, 13 Years	Mother, Female, 31 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 12 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 12 Years	Mother, Female, 31 Years	Lack of Supervision	Unsubstantiated	

Sibling, Female, 10 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 10 Years	Mother, Female, 31 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 8 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 8 Years	Mother, Female, 31 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 6 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 6 Years	Mother, Female, 31 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 6 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 6 Years	Mother, Female, 31 Years	Lack of Supervision	Unsubstantiated

Report Summary:
This SCR report was received with concerns that since 12/31/21, SM had left the SSs home alone. The 13yo SS was caring for the five younger siblings, including the 10yo who was developmentally delayed. The expectations for the care of the children were too high, and there was no food in the home.

Report Determination: Unfounded | **Date of Determination:** 03/04/2022

Basis for Determination:
The SSs denied the allegations and reported one of the BFs was caring for them while BM was hospitalized. Friends were also helping as needed. No safety concerns were disclosed by any of the SSs or collateral sources. Ample food was observed in the home. SC was born on 1/5/22 and was admitted to the NICU with no foreseeable discharge date. BM was interviewed and denied the allegations in the report. The SSs were deemed safe upon BM's return home from the hospital. BM agreed to voluntary preventive services to assist with finding new housing, childcare vouchers, and assistance with meeting the many needs of her CHN. The investigation was unfounded, and the services case was opened.

OCFS Review Results:
This investigation met all statutory requirements.

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

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

From 2011 to 2018, the SSs were listed as maltreated CHN in nine CPS investigations with common allegations of IF/C/S, IG, LS, SA, PD/AM, LMC, L/B/W, and EdN. Of these investigations, five were indicated.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 03/04/2022

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes

Date the Child Protective Services case was opened: 03/04/2022

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☐	☐	☒	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Preventive services were provided by a voluntary agency.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Following SC's death, the 11yo SS expressed thoughts of self harm. The record did not reflect the SS was spoken with regarding this, nor was there any follow up with the hospital regarding her MH evaluation and treatment recommendations.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	Case records must contain assessments of the problems, strengths and needs of the child and the family receiving services to promote valid decision making and planning and to support major decisions affecting the safety, permanency and well-being of children by careful, comprehensive and timely reviews and evaluations of all relevant material.

Preventive Services History

A voluntary preventive services case was opened in March 2022 to assist the mother with finding new housing, obtaining childcare vouchers, and meeting and navigating the many needs of her seven children. The subject child died while the case was ongoing. The family remained engaged in voluntary services 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