Child Fatality Report

Report Identification Number: NY-19-042

Prepared by: New York City Regional Office

Issue Date: Oct 31, 2019

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		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 05/02/2019
Initial Date OCFS Notified: 05/03/2019

Presenting Information

On 3/29/19, the SM tested positive for illicit drugs upon the delivery of the now one-month-old male child (SC); as a result, the SC was born at 24 weeks gestation and tested positive for cocaine at the time of birth. The SM's drug use contributed to the SC's ongoing medical conditions and complications. On 5/2/19, the parents, who were under the influence of an unknown substance acted hostile and were verbally aggressive with slurred speech and unsteady balance. The parents withdrew medical care for the SC and had his breathing tube removed. As a result, the SC, who was in critical condition, died at 3:06 PM. The report alleged the parents intentionally withdrew the SC's care despite having other treatment options because the parents did not want to be involved with ACS.

Executive Summary

On 5/3/19, the breathing tube was removed from the SC and he died at 3:06 PM. The SC had been born extremely premature at 24 of weeks gestation and he tested positive for cocaine. Since birth, he remained in the NICU at Maimonides Hospital (MH) where he had been diagnosed with Respiratory Distress Syndrome; he never left the hospital. The SC was treated for medical complications; however, there was minimal improvement. The attending Dr. along with a medical team met with the parents who, after being presented with the SC's critical condition, decided to remove the breathing tube which resulted in his death. The parents have no other children in their care and the SF has no other minor children.

ACS learned that after the SC's birth, the SM was discharged from the hospital, she and the SF carried their belongings in large garbage bags; they appeared homeless. The parents had not returned to the hospital until one month after the SC's birth. They had given contact information that could not be verified by the hospital staff who reported many attempts to contact the parents. ACS made numerous attempts to locate the parents to no avail.

On 5/2/19, a Child Safety Conference was held at the ACS field office and although the parents were notified of the conference they did not attend. ACS learned from MH staff that the parents attended a meeting with the medical staff and asked that ACS be excluded from the meeting. The parents expressed anger towards ACS because the agency was in the process of filing a neglect petition to have the SC removed from the parents' care. ACS learned the parents intentionally opted to have the breathing tube removed, despite having other treatment options.

On 5/3/19, the hospital staff had scheduled a time to remove the SC's breathing tube in the presence of the parents. According to the staff, the parents arrived at MH under the influence of an unknown substance, the SF's speech was slurred and his gait was unsteady balance; the SM eyes were red and she appeared sleepy.

On 5/7/19, ACS interviewed the attending Dr. at MH and it was reported that the medical staff agreed with the parents' decision to withdraw medical care from the SC. According to the Dr., the parents acted appropriately (no yelling or cursing) and that the SF wanted to know why the Dr. was torturing the SC. The Dr, agreed that the parents made the appropriate choice for the SC given the SC's medical prognosis.

The SM had three older children (SS) who were removed from her care due to her substance abuse. The parents' rights were terminated and two of the SS were adopted by the MGM. The MGM and fifteen-year-old SS reside out of state and they had not seen the SM for eleven years; however, two years ago, the SM showed up at court when the youngest child was adopted. The BF's of the SS had not been involved in their care.

On 5/7/19, ACS was contacted by the ADA's office who requested an update on the case involving the SC. After the briefing, it was stated that it did not appear that there was any criminality on the part of the parents. The DA's office would not be moving forward since the SC was hospitalized at the time of death and the breathing tube was not removed by the parents.On 5/11/19, ACS contacted LE who reported they found no criminality.

The SF admitted he relapsed and had been using heroin weekly. Both parents of the SC are in a drug treatment program and are in a methadone program.

On 6/27/19, ACS unsubstantiated the allegation of DOA/fatality of the SC by the parents citing a lack of credible evidence. On 6/27/19, ACS substantiated the allegations of IG and PD/AM of the SC by the parents, ACS cited the parents failed to exercise a minimum degree of care to the SC by abusing illicit substances during the pregnancy and both parents were under the influence of illicit substances.

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?** 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? 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:
There are no surviving siblings or other children in the home of the parents. The SS of the SC have been adopted by the MGM and reside out of state.

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: 05/02/2019 **Time of Death:** 03:06 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 alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

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	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)

LDSS Response

On 5/3/19, ACS responded to the report registered by the SCR regarding the death of the one-month-old male by visiting MH to obtain information. The reported allegations were DOA/ Fatality, IG and PD/AM of the SC by the parents. The parents had no other children in common.

ACS had an open investigation into this family when the SC had tested positive for an illicit drug at birth. During the initial report, the ACS Specialist interviewed the parents in MH and observed them under the influence of and they both admitted to heroin and cocaine use.

ACS interviewed the parents on 3/29/19 and they admitted to recent drug use while attending a methadone program. The parents stated they did not know the SM was pregnant until recently and they attended one prenatal care appointment. The SM stated she wanted the SF's family to care for the SC, if he survived, as the MGM already had custody of the SM's three children. Prior to the SM's discharge from MH, the parents gave an address to the Specialist; however, attempts to contact them were futile. The parents were uncooperative and upset that ACS attempted to remove the SC from their custody. The SF reported he has a mental health condition to which he has prescribed medication.

ACS learned from the MH staff that the parents signed a "do not resuscitate" form just prior to the SM's discharge on 4/1/19. The parents had not return to MH to see the SC or to receive updates on the SC's progress. During the month of

April, the MH SW attempted to contact the parents to no avail. According to MH staff, the SF visited the SC just prior to the SM's discharge and he was brash and shouted at the staff that the Dr. should give the SC medication to make him sleep because he was in a lot of pain.

According to ACS' case documentation on 5/1/19, the MH staff received a call from the SF who had agreed to meet with the SC's Dr. On the following day, the parents met with the MH staff asked the staff not to allow ACS to participate in the conference. The SW at MH reported the parents appeared under the influence of an unknown drug at the time of the conference. The Dr. provided the parents with an update on the SC's condition and the parents opted to withdraw medical care from the SC as opposed to permitting surgery. The SF stated the SC had suffered enough.

On 5/2/19, ACS contacted the MGM who reported she adopted the SM's three children and they reside out of state. The MGM reported the SM is not involved with the SS and she had last seen the SM in December of 2018.

On 5/7/19, ACS interviewed the MH Dr. who reported that after discussing the parents' decision with a medical team based on the SC's prognosis, the medical team agreed with the parents' decision to withdraw care. The Dr. added that the parents left MH before the SC was pronounced and they behaved appropriately based on the circumstance.

On 5/11/19, ACS contacted LE and they reported they found no criminality.
On 7/2/19, ACS unsubstantiated the allegation of DOA/Fatality of the SC by the parents citing no credible evidence was found. ACS substantiated the allegation of IG and PD/AM of the SC by the parents citing credible evidence was found. ACS cited credible evidence was found and cited the SM and SC's tests results when the SC was born.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051499 - Deceased Child, Male, 1 Mons	051500 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
051499 - Deceased Child, Male, 1 Mons	051500 - Mother, Female, 38 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
051499 - Deceased Child, Male, 1 Mons	051501 - Father, Male, 45 Year(s)	Inadequate Guardianship	Substantiated
051499 - Deceased Child, Male, 1 Mons	051500 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
051499 - Deceased Child, Male, 1 Mons	051501 - Father, Male, 45 Year(s)	DOA / Fatality	Unsubstantiated

051499 - Deceased Child, Male, 1 Mons	051501 - Father, Male, 45 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☐	☒	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The parents refused to cooperate with ACS after the death of the SC.

Fatality Safety Assessment Activities

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

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 parents refused to cooperate with ACS.				

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: The parents refused to cooperate with ACS.							

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 are no SS or other children in the home of the parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were not cooperative.

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?	Yes
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)
03/29/2019	Deceased Child, Male, 24 Hours	Father, Male, 45 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 24 Hours	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 24 Hours	Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SM gave birth to a male child (SC) at 24-weeks-gestation and he tested positive for cocaine. The SM stated she did not know she was pregnant. The SC remained hospitalized. The allegations were IG, and PD/AM of the SC by the SM and IG by the SF.

Report Determination: Indicated | **Date of Determination:** 05/28/2019

Basis for Determination:
ACS found credible evidence to indicate the allegations IG and PD/AM of the SC by the SM citing that the SM and SC

tested positive for cocaine at the time the SC was born. The SM failed to exercise a minimum degree of care; she abused illicit substances during pregnancy that contributed to the severely premature birth of the SC. ACS also stated that the parents elected to remove the breathing tube of the SC, who is currently deceased.

OCFS Review Results:
OCFS found that ACS completed a thorough investigation.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/03/2016	Sibling, Female, 2 Years	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 2 Years	Mother, Female, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 2 Years	Father, Male, 44 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Father, Male, 44 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
On 10/3/16, the SCR registered a report that alleged both parents misused drugs and people were in and out of their home to buy or use drugs. The ACS Specialist observed both parents under the influence of an unknown substance, and they unable to provide adequate care of the SS. On 10/24/16 ACS filed a remand and on 10/25/16 the SS was placed in foster care under the auspices of Coalition for Hispanic Families. ACS substantiated the IG, LS and PD/AM allegations citing a failure to meet the SS's basic needs such as medical and developmental needs. The SS was adopted by the MGM on 2/7/19.

Report Determination: Indicated **Date of Determination:** 10/29/2016

Basis for Determination:
ACS substantiated allegations PD/AM, IG and LS of the SS by the parents citing credible evidence. The ACS Specialist observed the SM left the SS alone in the home for an extended period of time. ACS cited the parents positive drug tests results. ACS also indicated the allegation of IG because the parents did not ensure the SS's medical and developmental needs were met.

OCFS Review Results:
ACS completed the necessary actions for the safety of the SS.

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

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

On 12/12/13, the SCR registered a report that alleged the SM had given birth to a baby girl (the now five-year-old SS) who tested positive for illicit drugs and was experiencing withdrawal symptoms. On 1/3/14, ACS attempted to file an Article 10 Neglect Petition on behalf of the SS; however, the SM enrolled and participated in a drug treatment program and Family Court did not accept the petition.

ACS initiated a Family Service Stage on 2/3/14 and closed the investigation stage. The SS was referred for early intervention services under the auspices of the SCO Family services agency. The parents did well and consistently passed drug screenings. The SS received intervention services and the parents cared for the SS and kept the home clean. The service case was closed on 7/18/14.

Known CPS History Outside of NYS

The SM had a history of CPS investigations outside of NYS from 2000 thru 2007 that resulted in the removal of the BM's two children. The MGM has legal custody of the SM's now fifteen-year-old child and the other child is now an adult. The MGM also obtained custody of the SM's now three-year-old SS until the adoption was finalized on 2/7/19. They all reside out of state and are not in contact with the SM.

Preventive Services History

The parents did not comply with the services resulting in the removal of the three-year-old SS, who has been adopted by the MGM.

Foster Care Placement History

The SM had three older children (SS) who were removed from her care due to her substance abuse. The parents' rights were terminated and the now fifteen-year-old SS was adopted by the MGM. The MGM and SS reside out of state and they had not seen the SM for eleven years; however, two years ago, the SM showed up at court when the three-year-old SS was also adopted by the MGM. The BF of the three-year-old SS had not been involved in her care.

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