Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-132

Prepared by: New York City Regional Office

Issue Date: May 18, 2018

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: 3 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 11/18/2017
Initial Date OCFS Notified: 11/21/2017

Presenting Information

On 11/18/17, ACS received additional information regarding the death of the three-month-old female SC in Connecticut where the SM and SC had been visiting with maternal relatives. The family is still in Connecticut. The SC has a condition known as Holoprosencephaly (HPE) which is a malformation of the brain. The SC died in Connecticut and information regarding the SC's death was received on 11/18/17.

Executive Summary

The three-month-old female SC was born medically fragile in August 2017. The SC was diagnosed with severe Holoprosencephaly (HPE syndrome) which was described as a malfunction of the brain in addition to numerous physical and medical issues. The SC died on 11/18/17, in Connecticut, where the SM was attending a family function.

On 8/30/17, the SCR registered a report that alleged IG of the SC by the parents because they were unwilling to have the SC admitted to a long term medical facility or pediatric hospice. The SM insisted on the SC's discharge home despite the fragile medical condition of the SC.

The SC was hospitalized in the Lincoln Hospital neonatal intensive care unit (NICU) from birth until 10/11/17, when she was discharged to the parents. The SC was readmitted on 10/13/17, for medical reasons. The SC was transferred to Montefiore Hospital for a higher level of medical care where she remained until she was discharged to the parents on 10/31/17.

The SM informed ACS she wanted the SC discharged home where she would care for despite her medical condition. Medical staff informed ACS the SM was informed of the seriousness of the SC's medical condition and poor prognosis. The SM refused to discuss placing the SC into a long term care facility with medical providers. ACS interviewed the SF who stated he and the SM were capable of caring for the SC.

On 9/5/17, ACS filed an Article 10 Neglect Petition in Bronx County Family Court where the case was adjourned because the SC was still hospitalized. On 9/26/17, the SC was released to the parents who had to comply with the Family Court order by following strict conditions and engaging in services because of the medical fragility of the SC.

ACS implemented multiple services to facilitate the care of the SC. These services included, early intervention, mental health/emotional stability supportive counseling, parenting skills, decision making/problem solving, visiting nurse services, and a ARCH care nursing program in addition to maintain all required medical appointments.

On 10/26/17, ACS substantiated the allegation of IG of the SC by the parents from the 8/30/17 report. The determination cited the parents' refusal to accept medical providers recommendation to place the SC in a facility where she would receive 24-hour care to address her medical needs. The determination also stated the SM did not have adequate provisions for the SC.

Between 10/31/17 and 11/16/17, ACS made multiple home visits and monitored the parent's care of the SC. The SC informed ACS she would be leaving New York State for a family function and she had all of the items necessary for the care of the SC.

On 11/18/17, ACS was notified of the death of the SC while away with the SM. ACS closed the services case because the there were no surviving siblings or other children in the home and the SM remained out of state for some time following the death of the SC. The cause of death was "complication of holoprosencephaly," and the manner of death was natural.

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:
ACS made the appropriate collateral contacts and obtained relevant information regarding the death of the SC.

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:
The case remained open for services after the investigation of the 8/30/17 report was determined. No report was registered as a result of the SC's death.

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: 11/18/2017 **Time of Death:** 10:31 AM

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

Was 911 or local emergency number called? Yes

Time of Call: 10:24 AM

Did EMS respond to the scene? Yes

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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 01
Adults: 00

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	3 Month(s)
Deceased Child's Household	Mother	No Role	Female	21 Year(s)

LDSS Response

On 11/18/17, ACS received additional information the SC expired at 10:31AM that morning in Westhaven, Connecticut. The SM was planning to attend a family function when the child died. According to information obtained by ACS, the Connecticut EMT declared the SC dead at 10:31AM following a call to 911 stating the SC was not breathing. Connecticut CPS informed ACS no child welfare report was registered in Connecticut because there was no suspicion of of neglect or maltreatment of the SC.

On 11/20/17, the ACS Specialist visited the parents home where the SF was interviewed, the SM was not present during the interview. The SF told the Specialist the SM informed him of the SC's death via telephone on the morning she died and that "everything was fine," before the SM and SC left for Connecticut the afternoon of 11/16/17.

On the same date ACS contacted Family Court Legal Services to inform Family Court of the SC's death and also contacted by telephone the adult maternal cousin (AMC) of the SM who provided an account of the incident which was consistent with information obtained by ACS. The neglect petition against the parents was withdrawn due to the SC's death.

The AMC told ACS the SM and SC were residing in the AMC's home at the time of the incident. ACS documented the AMC stated the SM and SC arrived at her home on 11/16/17, for a funeral of a family member which was to be held 11/19/17.

The AMC added on the morning of 11/18/17, the MGM came to her and stated the SC was not breathing and she called 911 at 10:24 AM and checked the SC who was pronounced dead by EMS technicians upon their arrival. The AMC informed ACS the SM had medication and food for the SC.

On the same date, ACS called Connecticut LE and interviewed a detective who stated the MGM informed LE she checked on the SC at 5:00AM because she was "fidgeting." The MGM returned to check the SC and she was not breathing and her body was stiff. ACS documented the detective stated the bedroom where the SM and SC slept contained a full size bed and

a car seat. The BM stated the SC slept in the car seat.

Between 11/22/17 and 1/17/18, ACS made numerous collateral contacts to obtain information pertaining to the SC's death.

On 1/17/18, ACS contacted the Connecticut ME's office and learned the cause of death was "complication of holoprosencephaly," and the manner of death was natural.

On 1/18/18, ACS closed the services case because there were no surviving children and no concerns the parents caused the death of the SC. The SM declined to make herself available to ACS and remained in Connecticut following the SC's death.

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: Medical Examiner

Multidisciplinary Investigation/Review

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.

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?	☒	☐	☐	☐

Additional information:
ACS obtained information from Connecticut CPS, ME, LE and family members the SM was visiting at the time of the SC's death.

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:
There are no surviving siblings or other children in the parents home. The parents had extensive services prior to the SC's death; however, the service cases were closed because the parents had no children under 18 years of age or other children in their home. In addition, the SM remained in Connecticut state for some time following the death of the SC and declined to contact 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 surviving siblings or other children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the

fatality? No
Explain:
The SM did not return to New York and the parents services case was closed because there were no children under the age of 18 in their care.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	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?	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)	Status/Outcome	Compliance Issue(s)
08/30/2017	Deceased Child, Female, 7 Days	Mother, Female, 21 Years	Inadequate Guardianship	Indicated	No
	Deceased Child, Female, 7 Days	Father, Male, 25 Years	Inadequate Guardianship	Indicated	

Report Summary:
On 8/30/17, the SCR registered a report that alleged IG of the SC by the parents. The report alleged the SC was born with severe congenital malformations and medical staff recommended the SC be put into a long term care facility and it was dangerous for the SC to go home with the parents.

ACS obtained COS through Family Court

Determination: Indicated
Date of Determination: 10/26/2017

Basis for Determination:
On 10/26/17, ACS substantiated the allegation of the report against the parents. ACS' determination narrative stated the

SM would not accept the recommendation of the medical staff to have long term care put into place for the SC who had a life span expectancy of less than one year. The determination also stated the SM and SF were unable to provide adequate provisions for the SC.

OCFS Review Results:
ACS made appropriate collateral contacts with medical providers regarding the SC. In addition, ACS filed an Article 10 Neglect petition for supervision of the parents and SC because of the medical fragility of the SC. ACS initiated homemaking services for the SC, medical PPRS services, and visiting nurse services. The SC died shortly after the services began and the parents had no surviving children. Family Court withdrew the Neglect petition because of the SC's death and the services case was closed.

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

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known history outside of New York State.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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