Child Fatality Report

Report Identification Number: NY-21-006

Prepared by: New York City Regional Office

Issue Date: Jul 15, 2021

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: 1 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 04/21/2020
Initial Date OCFS Notified: 01/15/2021

Presenting Information

On 4/21/20, the child was in the care of the parents. The mother fed the child a bottle of formula around 2:00PM, and then around 4:15PM the mother placed the child on a queen size bed and went to sleep in the same bed. The mother awoke around 5:20PM and found the child was still sleeping. At about 8:30PM, the mother went to check the child, as he had been sleeping for longer than normal. The mother found the child unresponsive, blue, and cold to the touch with vomit around his nose and mouth. The mother yelled for the father and 911 was called. EMS responded to the home and found the child unresponsive. The child was transported to the hospital, where he was intubated. Resuscitative efforts were continued at the hospital without success. The child was pronounced dead at 9:55PM on 4/21/20. The child died due to the exposure of multiple illicit substances and acute intoxication by the combined effects of drugs while in the care of the parents.

Executive Summary

This fatality report concerns the death of a one-year-old male subject child that occurred on 4/21/20. A report was made to the SCR on 1/15/21 with allegations of DOA/Fatality, Poison, Noxious Substances, and Inadequate Guardianship of the child by the parents. A previous Child Fatality Report regarding this child was issued by the New York State Office of Children and Family Services on 10/13/20. The Administration for Children's Services (ACS) had completed a fatality investigation at the time the child died; however, when that case was closed, a cause and manner of death had not yet been determined. The final autopsy indicated the cause of death as Acute Intoxication by the combined effects of Morphine, Fentanyl, and Tramadol. The manner of death was determined to be homicide. Given this new information, the fatality was re-reported to the SCR and a new investigation was initiated.

At the time of the child’s death, he resided with his parents. ACS established the father had three other children who resided elsewhere and with whom he had no contact.

The investigation which began on 1/15/21 revealed that after an initial phone contact with the mother who reported she was pregnant with twins and did not want any services from ACS, the parents refused to meet or engage with ACS. The parents retained the services of an attorney and for the duration of the investigation no additional contact was made with them. The attorney agreed to meet with ACS and the family and requested pre-prepared questions. ACS's Family Court Legal Services submitted questions to the parents attorney to explore the cause and circumstances of the child's death; however, neither the attorney nor the parents responded to ACS.

From the time the investigation began to the time of its closure, ACS interviewed collateral sources. However, neither law enforcement nor the Medical Examiner was successful in reaching the parents. ACS's contact with law enforcement revealed the District Attorney's Office had not yet made a decision regarding the case; therefore, no arrests had been made.

On 3/15/21, ACS substantiated the allegation of DOA/Fatality, Poison, Noxious substances and Inadequate Guardianship of the child by the parents on the basis of some credible evidence. ACS documented the parents failed to provide any explanation regarding the manner in which the narcotics entered the child's system, as these drugs would not have been administered via the emergency room and would not have been prescribed in this combination, for a child this age. As such, the parents who were legally responsible for the child, failed to protect the child, and their actions contributed to his death.

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?** Yes

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

Explain:
Casework activity was commensurate with case circumstances.

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:
The level of casework activity, was commensurate with the case circumstances.

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: 04/21/2020 **Time of Death:** 09:55 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:33 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- [x] 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 was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- [ ] Distracted
- [ ] Absent
- [ ] Asleep
- [ ] Other:

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 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Other Household 1	Sibling	No Role	Female	16 Year(s)
Other Household 1	Sibling	No Role	Male	3 Year(s)
Other Household 2	Sibling	No Role	Male	9 Year(s)

LDSS Response

ACS received the SCR report on 1/15/21 concerning the previously reported fatality that occurred on 4/21/20. The death was initially reported to the SCR on that same date and was investigated by ACS with the coordination of their multidisciplinary team. A Child Fatality Report regarding that investigation was issued by the New York State Office of Children and Family Services on 10/13/20.

On 1/15/21, ACS contacted LE regarding the status of their investigation. LE requested that ACS not contact the family as it could jeopardize the possible criminal case.

ACS contacted members of the mother's extended family and learned the mother was receiving counseling to cope with the death of the child. Family members refused to provide details regarding the whereabouts of the parents.

On 1/20/21, ACS contacted the mother via phone. The mother was informed there was a new report. The mother indicated she did not wish to discuss the death of the child as she was still grieving. The mother also declined ACS's offer of support and services. The mother said there were no other children in the home but noted she was pregnant with twins.

On 1/21/21, ACS spoke with the Medical Examiner who advised fentanyl, or a drug that mimics fentanyl, would not be found in any over the counter medications and that as part of the routine medical investigation, contact had been made with medical staff at the hospital where the child had been taken in April 2020. The Medical Examiner explained the child was administered drugs but not the drugs found in the child's body at autopsy. The Medical Examiner further detailed the extensive testing to confirm the drugs found. The Medical Examiner stated the toxicology results were received in October

2020; however, more expansive tests were ordered and the results received on 11/28/20, confirmed the presence of the drugs. According to the ME the parents gave no indication as to how the child may have been exposed to the drugs. ACS gathered no new information regarding who was responsible for the death of the child.

On 3/15/21, ACS substantiated the allegation of DOA/Fatality, Poison, Noxious substances and Inadequate Guardianship of the child by the parents on the basis of some credible evidence. ACS documented the parents failed to provide any explanation regarding the manner in which the narcotics entered the child's system, as these drugs would not have been administered via the emergency room and would not have been prescribed in this combination, for a child this age. As such, the parents who were legally responsible for the child, failed to protect the child, and their actions or inactions contributed to the child's death.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: Case documentation reflected there was a MDT response to the fatality.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057701 - Deceased Child, Male, 1 Yrs	057702 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
057701 - Deceased Child, Male, 1 Yrs	057704 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
057701 - Deceased Child, Male, 1 Yrs	057704 - Mother, Female, 32 Year(s)	Poisoning / Noxious Substances	Substantiated
057701 - Deceased Child, Male, 1 Yrs	057702 - Father, Male, 37 Year(s)	DOA / Fatality	Substantiated
057701 - Deceased Child, Male, 1 Yrs	057702 - Father, Male, 37 Year(s)	Poisoning / Noxious Substances	Substantiated
057701 - Deceased Child, Male, 1 Yrs	057704 - Mother, Female, 32 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS made brief telephone contact with the mother regarding the new report. The father was not interviewed. After the initial contact the parents refused to speak with ACS staff and retained the services of an attorney.

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	☐	☐	☐	☒	☐	☐	☐
Other, specify: IC							
Additional information, if necessary: In the initial contact with the mother ACS offered bereavement counseling. The mother declined and refused to meet with ACS. No offers of other services were possible.							

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 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 parents declined services, refused to meet with ACS for the entirety of the investigation and retained the services of an attorney.

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? No
Was the child acutely ill during the two weeks before death? No

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)
04/23/2020	Deceased Child, Male, 1 Years	Mother, Female, 32 Years	DOA / Fatality	Unsubstantiated	No

Deceased Child, Male, 1 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 1 Years	Father, Male, 37 Years	DOA / Fatality	Unsubstantiated
Deceased Child, Male, 1 Years	Father, Male, 37 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
This SCR report was received with concerns that on 4/21/20, the subject child died while in the care of the mother and father. The report alleged on 4/21/20 4:20 PM, the BM laid the SC in bed (on his back) to sleep with a bottle. At 5:15 PM, the BM returned to the room and checked the SC who was breathing and fine. The BM then got into bed and fell asleep next to the SC. At about 8:00 PM, the BM awoke and tried to wake the SC, who was on his left side near the wall. The SC was cold and unresponsive. He also had a laceration to his lip and a hole in his tongue from biting himself. The SC was taken to the hospital by ambulance and was pronounced dead at 9:55PM.

Report Determination: Unfounded | **Date of Determination:** 07/24/2020

Basis for Determination:
ACS unsubstantiated the allegations of the report on the basis of a lack of credible evidence. At the time of the SC's death, hospital staff and LE did not report any suspicions. While the SC was alive, the parents provided him with the minimum degree of care.

OCFS Review Results:
ACS received the report on 4/23/20 and initiated the CPS investigation in a timely manner. ACS obtained information from both medical and LE staff which did not indicate the SC's death was due to abuse/maltreatment. There was no criminality involved and LE did not make any arrest. ACS obtained additional information from the family, service providers, and neighbors. The BM was in receipt of therapy for a clinical health condition. There were no reported concerns for the family. At the time of the closing the Medical Examiner's report had not yet been completed; therefore, ACS based their decision on the information obtained during the investigation.

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

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