Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-18-131

Prepared by: New York City Regional Office

Issue Date: Jun 13, 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 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 12/27/2018
Initial Date OCFS Notified: 12/27/2018

Presenting Information

The SCR report alleged on 12/27/18, the SC (age 1) was sick at 4:00 A.M. The SM administered a small amount of Motrin and fed the SC a small amount of milk. The SM returned the SC to his crib and then returned to sleep in her bed. At approximately 10:00 AM, the SM checked the SC and observed the SC was unresponsive, (mucus was observed on the SC's cheek). The SM and SF, and an unknown male transported the SC in a vehicle and alerted LE. LE observed the SC unresponsive in the car. LE attempted CPR and transported the SC to the local hospital. The SC was an otherwise healthy child with no prior medical conditions. The SC's cause of death was unknown. The SC's death was suspicious.

Executive Summary

The 1-year-old SC died on 12/27/18. NYCRO received a copy of the final autopsy report in May 2018. The ME listed the cause of death as acute fentanyl, acetylfentanyl, heroin, dextromethorphan, and chlorpheniramine intoxication and the manner as homicide (ingestion of multiple narcotic drugs).

On 12/27/18, the SCR registered a report that included the allegations of DOA/Fatality and IG of the SC by the SM and SF.

ACS findings showed that on 12/26/18, the SM, SF and several friends smoked hookah and drank beer in the home. On 12/27/18, shortly before 4:00 AM, the SM gave the SC cough medicine because he was coughing. At approximately 4:00 AM, she fed the SC and left him sitting in his crib. The SM reportedly fell asleep and when she awoke at 10:00 AM, she found the SC lying face down with white mucus on his face. The MGM reported that she called EMS; however, the SM and SF decided to take the SC to the hospital in a livery cab because EMS was taking too long. The SM reported that she did not seek medical care for the SC’s cough. Although the SM did not seek medical care for the SC prior to the incident, the SM reported that the SC was ill and was taken to the hospital in November 2018. ACS did not interview the SF because his whereabouts became unknown after the death of the SC. There were no surviving children in the SM and SF's household, and therefore, no child safety assessments were required.

ACS staff interviewed LE and learned that on 12/27/18, the SM and SF attempted to transport the SC in a livery cab until they observed a police officer at approximately 10:15 A.M. According to LE's account, the SM and SF waved/alerted the officer and stated that the SC was unresponsive. LE observed vomit on the SC’s face. LE administered CPR to the SC; however, efforts to resuscitate the SC were unsuccessful. LE arrived at the local hospital with the SC and medical personnel attempted to revive the SC; however, attempts by hospital personnel to revive the SC were also unsuccessful. The medical personnel pronounced the SC dead at 11:11 AM.

ACS interviewed the attending physician and learned the SC arrived at the hospital free of marks and bruises; however, the SC had no pulse and was not breathing. The attending physician reported that the SM and SF were sober and displayed an appropriate grief response at the time they arrived at the hospital

On 2/25/19, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the SM and SF. The report was indicated based on information that was gathered throughout the investigation (the SM and SF had illegal heroin and fentanyl in the home and the SC’s toxicology report showed high levels of heroin and fentanyl in his system).

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

Explain:
ACS gathered sufficient information to make a determination for all allegations identified during the investigation.

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:
ACS obtained relevant information from LE, physician, babysitter, MGM, neighbors, and mental health, substance misuse, and domestic violence consultants.

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: 12/27/2018 **Time of Death:** 11:14 AM

Time of fatal incident, if different than time of death: 10:00 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 7 Hours
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☒ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

Between 12/27/18 and 12/28/18, ACS interviewed the SM and MGM. The SM reported that she last observed the SC alive on 12/27/18 at 4:00 A.M. after she fed him a bottle. The SM reported that she and the SF were asleep and when she awoke, she found the SC lying face down unresponsive in his crib. She said the SC had a cough a week prior to 12/27/18. She explained that she gave the SC over the counter medication every 3-4 hours to treat his cough.

On 12/27/18, ACS met with the Investigative Consultant team and learned that the SM and SF had no records of arrest or domestic incidents.

On 12/27/18, ACS interviewed the family's neighbors and learned that the SC often cried. The neighbors did not have any other concerns regarding the SC.

On 12/28/18, ACS interviewed social work staff at the local hospital. The staff said the SC was transported to the ER via NYPD sometime after 10:14 AM on 12/2718. The SC arrived at the local hospital unresponsive.

On 12/28/18, ACS noted the CPS team contacted an individual who was an employee in the subject family's building. ACS learned that the individual had knowledge of the family and he revealed SF was employed while the SM remained at home to supervise the SC.

On the same date, ACS interviewed an attending physician and learned that at the time the SC arrived at the hospital, he had a milky white substance around his mouth. According to this physician's account, the SC was wearing clean clothing

and dry diaper. The SC did not have observable signs of trauma, marks or bruises on his body.

On 12/31/18, ACS held a Family Team Meeting with the SM and MGM. ACS offered the SM and MGM burial assistance; however, the SM declined burial services. The SM denied illegal substance use. ACS obtained alcohol/substance abuse consultation for the case and learned that the SM reported she did not engage in substance use. The SM's drug test and toxicology report was negative for all illicit substances. During the Family Team Meeting, ACS did not discuss whether the SM and SF had knowledge of safe sleep practices.

On 1/3/19, ACS contacted the SC's physician to obtain information about the SC's health. The physician said the SC appeared healthy, had no observable marks/bruises and presented with no complaints. The physician explained that the SC did not have any pre-existing medical condition.

Also on 1/3/19, ACS interviewed the SC's babysitter and learned that the SC was ill and had a cough two weeks prior to 12/27/18. The babysitter stated that the SM utilized a nebulizer machine and cough medicine to treat the SC's cough. The babysitter did not have concerns regarding the care the SM provided the SC.

On 1/25/19, ACS contacted LE and learned that the SM was arrested on drug possession charges. LE reported that ME's preliminary findings revealed SC's toxicology results showed the SC was given significant levels of fentanyl.

On 2/12/19, ACS contacted the ME and verified the results of toxicology report showed the SC had fentanyl and heroin in his body, that was probably ingested or inhaled by the SC.

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: The investigation adhered to previously approved protocols for joint investigation.

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 New York City Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
049961 - Deceased Child, Male, 1 Yrs	049963 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
049961 - Deceased Child, Male, 1 Yrs	049963 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
049961 - Deceased Child, Male, 1 Yrs	049964 - Father, Male, 28 Year(s)	DOA / Fatality	Substantiated
049961 - Deceased Child, Male, 1 Yrs	049964 - Father, Male, 28 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:

There were no "other persons named" in the report.

There were no surviving children in the household and no other children in the SM's and SF's care.

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?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Other - Criminal Possesstion of a controlled substance	**Degree:** 1		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Criminal Charges were filed against the SM	Pending	Pending
Comments:	The SM was arrested on 1/24/19 for criminal possession of a controlled substance in the 1st degree.		

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:
ACS referred the SM to bereavement counseling, alcohol/substance abuse and domestic violence assessment. The SM's drug test was negative for all illicit substances.

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 SS or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There were no immediate needs related to the fatality. The SF whereabouts were unknown.

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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

Additional Local District Comments

There are no additional Local district comments.

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