Child Fatality Report

Report Identification Number: NY-19-013

Prepared by: New York City Regional Office

Issue Date: Aug 05, 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: 6 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 02/05/2019
Initial Date OCFS Notified: 02/06/2019

Presenting Information

The narrative of the report alleged on 2/5/19, the BM went to work in the morning and left the six-year-old SC in the care of his babysitter (UHM) with whom the family had resided for two years. At about 11:30AM, the UHM fed the SC. The SC then went into his bedroom. The UHM took several medications which caused her to sleep. The UHM fell asleep sometime after the SC ate lunch and was asleep till about 7:00PM when the BM returned home from work. After the BM returned home, she checked the SC and found him in bed unresponsive. At 7:16PM, the BM called 911 and EMS responded, but the SC was unable to be resuscitated. The SC was an otherwise healthy child with no obvious signs of abuse.

Executive Summary

The six-year-old male SC died on 2/5/19 while in the care of an unrelated home member (UHM) who was his babysitter. At the time of writing this report, the ME's report was pending; however, preliminary autopsy results found methadone in the SC's system.

A review of ACS case documentation revealed that on 2/5/19, the BM went to work and left the SC in the care of the UHM with whom the family had resided for two years. At about 11:30AM, the UHM fed the SC. The SC then went into his bedroom. The UHM took some medication for an unidentified medical condition and went to sleep in the living room, leaving the SC unattended in the bedroom. At 5:00PM, the UHM woke up momentarily but did not check on the SC. She went back to sleep. At approximately 7:00PM, the BM came home from work, checked the SC and found him unresponsive. The BM tried to revive the SC by applying cold water to his face and informed the UHM to contact 911. EMS responded to the home within minutes, took over CPR and then transported the SC to the hospital. The hospital staff also tried to resuscitate the SC without success and pronounced him dead at 7:53PM.

At the time of the fatality, the SC and the BM resided with the UHM. The BM and the SC had an active full stay away OOP against the BF due to DV.

On 2/6/19, ACS received the SCR report and contacted the ER Dr. and LE. The ER Dr. stated there was no sign of trauma to the SC. LE stated there was no arrest pending the ME's report. ACS also obtained information from the family and pertinent collaterals which revealed the UHM had a history of heroin use and was in a methadone program, but she continued to test positive for heroin use despite being prescribed methadone. Toxicology reports from the UHM's substance program reported high levels of opiates in her system. She last tested positive for opiates on 2/4/19. The BM denied knowledge of the UHM's substance use or being in a methadone program. She denied substance use or any history of, or current clinical health conditions.

ACS received medical reports which confirmed that prior to his death, the SC was a well child. He did not have any known hospitalizations and was up to date with his immunizations. There were no concerns regarding the care the SC received. Also, the SC was enrolled in school and received school based services for speech and language impairment.

During the investigation, the UHM retained the services of an attorney and refused to correspond directly with ACS any further. ACS offered moral support and bereavement counseling to the parents but they declined. The BF declined batterer's accountability and substance abuse services.

ACS has not yet determined this investigation. LE's investigation to the SC's death continued.

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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
There are no surviving siblings or other children in the home to assess.

Was the decision to close the case appropriate? Unknown

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 had not made a determination of the CPS investigation.

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: 02/05/2019 **Time of Death:** 07:53 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 07:17 PM
Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? Yes

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? 04 Hours
At time of incident supervisor was: Unknown if they were 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	6 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	65 Year(s)
Other Household 1	Father	No Role	Male	38 Year(s)

LDSS Response

On 2/6/19, ACS contacted EMS, the ER Dr. and LE. EMS and the ER Dr. stated there was no sign of trauma on the SC. LE reported the family's home was unkept and dirty. There were several dogs in the home. LE observed a bottle of methadone in the home. LE deemed the home a crime scene but did not make any arrest pending the ME's report.

ACS visited the case address to interview the family. The UHM reported she was caring for the SC on the day of his death, but did not know how the SC died. She admitted having a history of cocaine and heroin use. She was enrolled in a methadone program and was readmitted several times, most recently on 12/17/18. The BM denied knowledge of the UHM's substance use. She also denied having any concerns about the SC being in the UHM's care. The BM denied substance use or having any clinical health issues. She voluntarily engaged in therapy due to DV and anger problems. ACS advised the BM to inform her therapist about the SC's death to better support her deal with her loss. The family's neighbors reported concerning behaviors for the UHM.

Also on 2/6/19, ACS contacted the BF. He reported he last saw his son on 12/23/18 and did not observe anything unusual with the SC at the time. He did not have any information about what led to the SC's death. According to ACS, the BF appeared intoxicated and smelled marijuana. ACS addressed the BF's marijuana use. He stated he only wanted to talk to ACS about his son's death and was not willing to discuss his marijuana use. ACS offered the BF bereavement counseling, substance abuse treatment, and batterer's accountability services but he declined.

On 2/7/19, the SC's school reported the SC received school based services for speech and language delay. The school did not report any other concerns for the SC.

On 2/7/19, the UHM's therapist stated the UHM was compliant with attendance and obtained her methadone; however,

she continued to test positive for heroin use. She last tested positive for opiates on 2/4/19.

On 2/8/19, the ME reported that the preliminary autopsy revealed the SC tested positive for methadone.

On 2/11/19, the SC's primary care provider (PCP) reported the SC was a well child. He was current with his immunizations. The PCP did not report any concerns about the care the SC received.

On 2/11/19, ACS received the results of the BM's drug test which she took on 2/8/19. The results were negative.

On 2/12/19, the UHM's attorney contacted ACS and asked all communications concerning the UHM be forwarded to the attorney's office.

On 2/13/19, LE reported the UHM was allowed back into case address and that the methadone found in the home was sent to the laboratory for testing.

On 2/19/19, ACS contacted the BF. He continued to decline all services offered and stated he wanted employment services. ACS assisted the BF to search for agencies that could provide the BM with jobs.

On 2/26/19, LE stated the results of the SC's blood analysis were being awaited to determine if any arrests would be made.

On 2/28/19, the BM stated she was attending therapy and actively seeking employment. She requested assistance for housing services.

On 3/1/19, the therapist reported the BM was compliant with her therapy sessions. The therapist was exploring additional resources to help the BM deal with her loss.

On 5/21/19, the BM's therapist reported the BM was no longer in therapy. The BM had missed several appointments and did not return the therapist's phone calls.

On 4/3/19, 5/6/19, and 5/29/19, ACS contacted the ME. The ME stated the final autopsy was pending. Also, the ME had not determined whether the methadone was given to the SC or whether he ingested by himself.

ACS had not determined the CPS investigation; however, LE's investigation to the SC's death is ongoing.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical 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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
049172 - Deceased Child, Male, 6 Yrs	049173 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending
049172 - Deceased Child, Male, 6 Yrs	049174 - Unrelated Home Member, Female, 65 Year(s)	Inadequate Guardianship	Pending
049172 - Deceased Child, Male, 6 Yrs	049173 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending
049172 - Deceased Child, Male, 6 Yrs	049174 - Unrelated Home Member, Female, 65 Year(s)	DOA / Fatality	Pending

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?	☒	☐	☐	☐

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.

Have any Orders of Protection been issued? No

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	☐	☐	☐	☐	☐	☒	☐

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

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

The BF had one indicated report dated 6/7/14 due to a DV incident between the parents. The BF assaulted the BM with a glass bottle and made threats to harm her and the SC. As a result, the BF was arrested and a neglect petition was filed against him in Brooklyn Family Court. The SC was released to the BM with ACS supervision. Supervision of the family ended in August 2015 and an OOP was issued against the BF. The OOP was active at the time of the fatality.

The UHM had an indicated report dated 11/9/06. The UHM abused drugs and alcohol and was often impaired while caring for her 8-year-old grandson. She provided the child cigarettes. The child and his BM resided with the MGM at the time. During the investigation, the UHM admitted to giving the child cigarettes while in her care. ACS substantiated the allegation IG and PD/AM against the UHM. The child and his BM relocated to a DV shelter.

Known CPS History Outside of NYS

The family did not have any 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

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