Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-21-067

Prepared by: New York City Regional Office

Issue Date: Nov 29, 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: 2 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 06/08/2021
Initial Date OCFS Notified: 06/08/2021

Presenting Information

The SCR received four reports regarding the death of the two-year-old female child. The reports alleged on 06/07/21 the mother placed the two-year-old down to sleep on a pile of laundry on the bedroom floor adjacent to numerous coins and rings. The child had a history of placing coins and rings in her mouth. The mother fell asleep. At approximately 11:30PM the mother awoke to find the child unresponsive, rigid, and a little blue. The mother called 911 and first responders transported the child to the hospital where she was pronounced dead at 12:09AM on 6/8/2021. The mother had no explanation for why her otherwise healthy child died.

Executive Summary

This fatality report concerns the death of a two-year-old female subject child that occurred on 6/8/21. A report was made to the SCR on that same date with allegations of DOA/Fatality, Inadequate Guardianship and Lack of Supervision of the two-year-old child by the mother. The Administration for Children's Services (ACS) received the report and investigated the child's death. An autopsy was completed; however, as of 11/29/21, OCFS had not received a copy of the final autopsy report.

At the time of the child's death, she resided with her mother in a family shelter. There were no surviving siblings or other children in the household. The father of the child did not reside in the household and did not have ongoing contact with the mother or child.

ACS' investigation revealed on 6/7/21, the mother went to the methadone clinic with the child as she was accustomed to doing and after completing her visit, she returned home. Sometime after 4:00PM both the mother and child went to bed. It was unknown if the child went to sleep. At about 10:00 PM, the mother awoke and at about 11:00 PM she noticed that the child was unresponsive and blue when she checked. The mother called for emergency medical assistance after 11:37 PM. EMS responded to the home at 11:45 AM and transported the child to the hospital for additional treatment. At the hospital it was discovered the child had methadone in her system.

ACS interviewed pertinent collateral sources including law enforcement and learned, the mother had some unused methadone in her refrigerator, which was part of her "take home" dose for over the weekend. The mother often stored the methadone in an uncovered "Sippy" cup in the back of the refrigerator or a Poland Spring brand sports water bottle. The mother admitted the child liked to drink from the sports bottle and could have ingested the methadone from the bottle. Law enforcement surmised the child ingested the methadone by drinking from the mother's supply. Law enforcement reported the child's death was being investigated as a potential homicide.

As part of the investigation, the Specialist contacted the ME and learned the child had a skull fracture which appeared "recent" however could not be definitively dated. The ME indicated that the skull fracture was "sizeable" with hemorrhaging and appeared fresh. The ME further added there was also bruising on the child's upper neck in line with the skull fracture and a small amount of bleeding on the brain. Additionally, the child's urine was tested and was positive for methadone.

In the early stages of the investigation the mother was offered services; however, she declined and as the investigation progressed the mother retained the services of an attorney and refused to speak to ACS staff on the advice of her attorney.

ACS substantiated the allegations of the report against the mother on the basis of some credible evidence. ACS documented the child was able to gain access to the mother's "take home" methadone which was not properly secured and ingested it. The child subsequently died.

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:
Sufficient information was gathered to make a determination for all allegations listed on the report at intake.

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, which includes contact with the family and others from the receipt of the report through case conclusion, was commensurate with the case circumstances. There was documentation of supervisory consultation during the 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: 06/08/2021 **Time of Death:** 12:09 AM

Date of fatal incident, if different than date of death: 06/07/2021
Time of fatal incident, if different than time of death: 11:30 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 11:45 AM
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? 7 Hours
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	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)

LDSS Response

On 6/8/21, ACS received the SCR report regarding the death of the child, which occurred on that same date. ACS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACS learned there were no surviving siblings or children in the home. ACS also contacted, law enforcement, the shelter where the incident took place, and service providers.

The Specialist interviewed the mother who reported the child had been healthy and did not have any medical issues or conditions that could have caused her death. The mother stated the child's immunization and blood work were current and signed a HIPAA for the release of medical information. The mother provided additional details regarding the family, their supports, and resources. The mother stated the father was not involved with the family.The mother then retained the services of an attorney and refused to speak with ACS.

From service providers ACS learned the mother participated in her treatment program. Providers indicated the mother was always with the child. None expressed any concerns with the level of care the mother provided the child.

On 6/8/21 and 7/25/21, law enforcement reported that when the mother heard the child had methadone in her system, the

mother began to cry and told detectives she had some unused methadone in her refrigerator which was part of her “take home” dose for over the weekend. She further explained she usually stored the methadone in a “Sippy” cup with no lid in the back of the refrigerator or a Poland Spring brand sports water bottle from which the child liked to drink. The mother surmised the child may have ingested the methadone from the bottle. Detectives shared with ACS that the mother appeared to be "high" when they met with her and described her swaying with her eyes closed. Law enforcement further stated the death of the child was being investigated as a potential homicide.

Following the detectives' interview with the mother, the Specialist interviewed the mother; however, the mother refused to repeat the events leading to the child’s death. The mother stated the child took a nap at about 4:00PM. The child was asleep on a mat next to the mother's bed because she did not like sleeping in her crib.

The Specialist contacted the mother’s friend who had been on the phone with the mother at the time the mother found the child unresponsive. The friend stated that the mother called her at approximately 11:37PM and informed her that she had just woken up and that the child was still asleep. The friend said she overheard the mother attempting to wake the child and then heard the mother say the child was blue and was not waking up; the phone disconnected.

The Specialist contacted medical personnel and confirmed the time of death as 12:09AM on 6/8/21. Medical personnel reported extensive efforts were made for resuscitation; however, the attempts were futile. Medical personnel further indicated the mother did not ride in the ambulance with the child and arrived after the child was pronounced dead.

On 7/6/21, mental health and substance abuse consultations were secured. The Specialist contacted the mother’s service provider regarding treatment. There were no concerns noted.

On 7/29/21, the Specialist contacted the Investigative Consultant and the assigned homicide detective and learned the criminal investigation was ongoing.

Also, on 7/29/21, the Specialist contacted the ME’s Office and learned results of the autopsy were still pending. According to the ME there were signs of a skull fracture found; the fracture was “sizeable” with hemorrhaging and appeared fresh. The ME added there was also bruising on the child’s upper neck in line with the skull fracture and a small amount of bleeding on the brain. The ME confirmed that the child’s urine was tested and was positive for methadone.

ACS substantiated the allegations of the report based on credible evidence obtained during the investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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 the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058921 - Deceased Child, Female, 2 Yrs	058923 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated
058921 - Deceased Child, Female, 2 Yrs	058923 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
058921 - Deceased Child, Female, 2 Yrs	058923 - Mother, Female, 26 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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 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 mother refused contact with ACS after retaining the services of an attorney; therefore no services were provided.

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? Yes
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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/15/2019	Deceased Child, Female, 1 Days	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 1 Days	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 1 Days	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The mother who delivered a baby girl on 5/15/19, tested positive for heroin and methadone at delivery. The mother used five bags of heroin two days before delivery. The role of the child's grandmother was unknown.

Report Determination: Indicated **Date of Determination:** 06/12/2019

Basis for Determination:
ACS substantiated the allegations of Parents' Drug/Alcohol Misuse as it pertained to the newborn by the parents based on the positive toxicology of the mother and child plus the fact that the newborn was experiencing symptoms of withdrawal. Additionally, the father disclosure continued heroin and marijuana use which continued after the birth of the newborn. ACS also substantiated the allegation of Inadequate Guardianship of the child by the mother based on the mother's drug use.

OCFS Review Results:
The investigation of the report was initiated in a timely manner. The safety assessment was appropriate. ACS made contact with the appropriate collaterals, and the determination accurately reflected case circumstances. There was evidence of supervisory input both at designated timeframes and at critical points in 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.

Foster Care Placement History

On 05/21/19, an Article 10 Petition was filed against the parents due to concerns around the parents drug use. A remand was granted and the child was placed in non-kinship foster care. The subject child remained in foster care from 5/21/19 until 8/1/19.

Over ACS's objections in court, the child was discharged to mother who entered a mother-child program. ACS objected to

the discharge on the grounds that the family needed strict supervision. The Court released the child to the mother with COS, which began from 8/1/19.

On 8/30/20, a conference was held. ACS asked for an extension of supervision. The Court denied the request as the shelter where the mother was residing, testified to court that they would provide oversight of the mother and child. ACS conducted a review of the case and noted the mother tested negative at planned and unplanned drug testing times. Since mother appeared to be in compliance with the service plan COS ended on 10/28/20 and the case was closed.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/21/2019	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	058923 Mother Female 26 Year(s)	
Comments:	An Article X petition was filed against the parents for concerns related to drug use. A remand was granted to the Commissioner of ACS.	

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