Child Fatality Report

Report Identification Number: SV-22-007

Prepared by: New York State Office of Children & Family Services

Issue Date: Sep 09, 2022

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: 5 year(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 03/21/2022
Initial Date OCFS Notified: 03/21/2022

Presenting Information

An SCR report was received which alleged that on 3/20/22, the mother and father administered two milliliters of oxycodone to the five-year-old subject child as part of his recovery from nasal surgery. The mother noticed the child was coughing at 3:00AM on 3/21/22, but it was unknown if the mother gave the child anymore medication. At 5:00AM, the mother found the child unresponsive and immediately called 911. Emergency medical technicians responded and transported the child to the hospital where he was pronounced deceased. The parents had no explanation for the child's death.

Executive Summary

This fatality report concerns the death of a five-year-old male subject child that occurred on 3/21/22. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother, father, maternal great-grandmother (MGGM) and an unrelated home member (UHM). Westchester County Department of Social Services (WCDSS) received the report and investigated the child's death. An autopsy was completed, and the final report noted the cause of death as "Acute oxycodone intoxication and positional asphyxia in a five-year-old child with sleep apnea, five days after tonsillectomy/adenoidectomy." The manner of death was accidental, with additional information that stated, "given high therapeutic dose(s) of oxycodone while recovering from tonsillectomy."

At the time of the child's death, he resided with his mother, father, six-year-old surviving sibling, and an unrelated home member, who rented a room in the residence. The maternal great-grandmother lived in another country but was visiting the family at the time of the incident. The investigation revealed that the subject child was born with congenital anomalies that impacted his health and development. He was non-verbal, and had recently been diagnosed with sleep apnea, which effected his sleep and breathing at night. On 3/16/22, the subject child underwent a surgical procedure related to the sleep apnea, and there were no complications. The child was discharged from the hospital the following day, and prescribed liquid oxycodone, 2 milliliters orally every four to six hours for severe pain. On 3/20/22, the child reportedly received a dose of oxycodone around 7:00PM and went to bed at approximately 10:30PM. The child awoke from coughing around 3:00AM, and the parents adjusted his pillows to prop his head and alleviate the coughing. The parents and the subject child then went back to sleep. The mother awoke around 5:00AM and noticed the child had not been snoring as he usually did. When she checked on the child, she found him unresponsive in his bed. The mother could not recall what position the child was in at that time. The mother woke the father, who began cardiopulmonary resuscitation, and the mother called emergency services. An ambulance transported the child to a local hospital, where he was pronounced deceased at 6:05AM on 3/21/22.

WCDSS spoke with family members and collateral sources. The surviving sibling was observed on several occasions and was deemed safe. WCDSS offered the family grief and bereavement referrals following the fatality. The record noted that a fair preponderance of the evidence was not gathered and therefore, the case was unfounded and closed.

PIP Requirement
This review resulted in a citation related to casework practice. In response, WCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the WCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
WCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving sibling.

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 notes a consultation took place, but no details noted.

Explain:
The case record reflected supervisory consultations throughout the investigation. 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

Issue:	Adequacy of Progress Notes
Summary:	It was learned after the investigation concluded that follow up with some medical professionals, including the medical examiner, prescribing doctor, and pharmacy, were either completed or attempted, and the information gathered concluded the subject child was cared for appropriately and there were no concerns of abuse or neglect. Additionally, it was discovered there was a language barrier between the parents and the doctors involved in the subject child's care, which caused concern as to how well the discharge instructions were understood by the parents upon leaving the hospital.

	Although these casework activities were completed, they were not documented in the case record. Lastly, early into the investigation, law enforcement expressed a concern that a chain was found on a bedroom door, and the parents reportedly used it to lock the subject child in the room when they were unavailable to supervise him. This was explored by WCDSS; however, discussions surrounding such were not documented in the case record.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must include descriptions of actions taken in the investigation for a reported case of child abuse or maltreatment, including emergency and/or controlling interventions taken, and descriptions of collateral contacts and other activities relating to the collecting of information needed to formulate an assessment and/or assist with making a determination regarding the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/21/2022 **Time of Death:** 06:05 AM

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

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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
How long before incident was the child last seen by caretaker? 2 Hours
At time of incident was supervisor impaired? Not 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	5 Year(s)

Deceased Child's Household	Father	Alleged Perpetrator	Male	46 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	78 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	43 Year(s)

LDSS Response

On 3/21/22, WCDSS met with the family at their home. SM and SF were interviewed; however, SF answered the questions as SM was upset and unable to engage with the caseworker. SF reported that SC had recently been diagnosed with sleep apnea, which caused him to have difficulty breathing when he slept. SF said SC saw a specialist and it was decided surgery was the best option for him. He explained the original date of the surgery was over a year ago; however, it was postponed several times due to the global pandemic. SC finally had the surgery on 3/16/22 and was prescribed liquid oxycodone for any pain. The record did not reflect if WCDSS asked SF the dosage or his understanding of how to administer the medication. SF stated SC also had issues with chronic congestion, which was caused by the sleep apnea. SF explained that on 3/20/22, it was a normal day and nothing out of the ordinary occurred. He stated the family watched movies all day, and around 7:00PM, he made dinner, and then SC was given his pain medication by SM. SF said at around 8:30PM, he went upstairs to watch TV in his and SM's bedroom, while SM got the CHN ready for bed. He stated SM and the CHN went to bed around 10:30PM, and he and SM next awoke around 3:00AM on 3/21/22 because SC was coughing. SF stated he propped some pillows under SC's head as that position usually alleviated his coughing. SF said SC eventually fell back to sleep, and so did he and SM. SF said SM woke up at 5:00AM and found SC not breathing. He explained he picked SC up from the bed and brought him down to the living room while SM called 911. SF said the police arrived first and began CPR, and then the ambulance came. SF explained he and SM followed behind the ambulance in their car to the hospital. As WCDSS continued asking questions, SM began to engage in the interview. SM stated SC had no complications following the surgery other than coughing during the night, and SC would seldom cough during the night before the surgery. WCDSS inquired whether SC's doctor was contacted due to this, and SM stated they had not yet scheduled SC's follow up appointment, as she was told he did not need to be seen for 2 to 3 weeks. The parents reported they could not recall what position SC was in when he was found unresponsive, and SM had awoken at 5:00AM that morning because she had not heard SC snoring as he usually did. SM stated SC had been acting like his normal self the previous day and was very active. WCDSS then interviewed the SS, who was quiet, but appeared free from suspicious marks and bruises and did not disclose anything concerning. The home was also assessed to meet minimal standards. It was noted the family slept in the same room together, and each CH had their own bed.

On 3/23/22, WCDSS received the medical records regarding SC's discharge after his surgery. It was noted the surgery was performed on 3/16/22 and SC was discharged on 3/17/22. SC was diagnosed with loud snoring and morbid obesity, as well as congenital anomalies that impacted SC's overall health and development. The records noted a follow up appointment needed to be scheduled within 2 to 4 weeks, SC was prescribed ibuprofen every 6 hours and oxycodone, 2 milliliters by mouth every 4 hours as needed for severe pain. WCDSS also received a photo of the bottle of oxycodone from LE; however, a description of the photo or the prescription label was not documented in the case record.

On 3/31/22, WCDSS met with SM to clarify information surrounding SC's medication. SM stated the oxycodone was prescribed 2 milliliters every 4 hours as needed, and although SC did not speak, he could make his needs known if he was in pain. She reported she would give SC the oxycodone in the evening, and she gave him his first dose on 3/17/21. SM explained she did not give him any on 3/18/21 because he was sleeping okay. SM stated she recalled she attempted to give SC the medication on another day, but he refused to take it due to the taste; she could not recall which day. The record did not reflect any further questions were asked surrounding the medication or when and how it was administered.

WCDSS also spoke with UHM and MGGM. UHM reported he was not at home when the incident occurred, as he was

working. UHM reported he did not notice anything unusual about SC's behavior and denied any safety concerns surrounding the parents' care of the CHN. MGGM stated she did not reside in the home but was there visiting from another country when SC died. She denied she was a caretaker for the CHN and had no additional knowledge surrounding the fatality. MGGM further reported no concerns surrounding the parents or the CHN.

WCDSS received information from the ME that there was a concern of possible oxycodone overdose. After the final autopsy was received, it was learned the amount of oxycodone found in SC's system was not considered a lethal dose. WCDSS noted a fair preponderance of evidence was not found to establish that the caretakers' actions or inaction led to the death of SC. WCDSS provided the family with referrals for grief and bereavement services, and unfounded and closed the investigation.

Official Manner and Cause of Death

Official Manner: Accident
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: This fatality investigation was conducted by the Westchester County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was submitted for review by the Westchester County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061266 - Deceased Child, Male, 5 Yrs	061267 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
061266 - Deceased Child, Male, 5 Yrs	061267 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
061266 - Deceased Child, Male, 5 Yrs	061268 - Father, Male, 46 Year(s)	DOA / Fatality	Unsubstantiated
061266 - Deceased Child, Male, 5 Yrs	061268 - Father, Male, 46 Year(s)	Inadequate Guardianship	Unsubstantiated
061266 - Deceased Child, Male, 5 Yrs	061269 - Unrelated Home Member, Male, 43 Year(s)	DOA / Fatality	Unsubstantiated
061266 - Deceased Child, Male, 5 Yrs	061269 - Unrelated Home Member, Male, 43 Year(s)	Inadequate Guardianship	Unsubstantiated
061266 - Deceased Child, Male, 5 Yrs	061270 - Grandparent, Female, 78 Year(s)	DOA / Fatality	Unsubstantiated
061266 - Deceased Child, Male, 5 Yrs	061270 - Grandparent, Female, 78 Year(s)	Inadequate Guardianship	Unsubstantiated

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:

WCDSS interviewed the family and received information from collateral sources. The unrelated home member was interviewed via phone, as face to face attempts were unsuccessful. Progress notes and other documentation were completed and entered timely.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☐	☒
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: Sufficient information surrounding the subject child's death was not gathered, and therefore, the accuracy of the RAP was unable to be determined. WCDSS offered the family victim assistance services, which they accepted.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The surviving sibling did not need to be removed as a result of this fatality report and was deemed safe in the care of her parents.				

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:
WCDSS offered the family referrals for grief and bereavement counseling as well as information surrounding funeral cost assistance.

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? Yes
Explain:
Service referrals were offered to the parents for the surviving sibling following the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Service referrals were provided to the caregivers following the fatality.

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? 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

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