Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-058

Prepared by: New York City Regional Office

Issue Date: Nov 21, 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: 16 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 05/23/2019
Initial Date OCFS Notified: 05/23/2019

Presenting Information

According to the SCR narrative, at approximately 3:00 PM, the SM found the SC laying in her bed with vomit around her mouth and she appeared pale with blue lips. EMS was contacted and LE and Paramedics attempted to resuscitate her; she was pronounced dead at 4:03 PM. The narrative alleged the SM and MGM were aware of the SC's substance abuse and that she needed a higher level of supervision. The allegations of the report were DOA/Fatality, LS, IG and CD/A of the SC by the SM and MGM.

Executive Summary

On 5/23/19, the sixteen-year-old SC was found in bed by the SM, unresponsive. The SM alerted other family members and the Adult Sibling (AS)2 contacted 911. The AS2 attempted CPR as instructed by the operator. LE and FDNY paramedics responded to the home and the paramedics pronounced the SC dead at 4:03 PM. The ME transported the SC to Kings County Hospital Morgue.

ACS interviewed the first responders, family and collaterals. ACS learned that there were no other children in the home and the BF was no longer involved in the SC's life. The AS2 and the MGM were in their apartment on another floor in the home when they heard the SM's cries for help.

ACS learned from LE that drugs and paraphernalia were found in the home at the time the SC was discovered. The SM told LE and the Paramedics that in the past, the SC drank alcohol until she passed out and she had recently been smoking marijuana. LE found no criminality and closed the case.

The SM stated that on the day of the incident, she and the SC had breakfast together. She left the SC at home as she went out to run errands. She returned at approximately 1:00 PM and checked, the SC was fine. At approximately 3:00 PM, she checked again to discover the SC lying in her bed with vomit, her lips appeared blue in color and her face pale. The SM, AS and MGM told the Specialist the SC had been using alcohol in the past and marijuana recently; however, they were not aware of current use of other illegal substances. The SC had been diagnosed with medical and mental health conditions to which she had prescribed medication; however, the family wAS not sure whether she was taking the medication.

The SM, AS2 and MGM admitted that they did not closely monitor the SC as they were distracted by their own issues. The SM and MGM explained their failed attempts to ensure the SC attend school; however, they recently opted to home school the SC. ACS found out from the school that no letter of intent to home school for the 2018-2019 school year had been submitted by the SM.

On 6/5/19, ACS learned from the Dr. at Mt. Sinai Hospital that the SM brought the SC for a second opinion; her last check-up occurred on 3/28/19. The SC's medical condition was under control and was not significant to cause sudden death. The Dr. reported the SC did not want to attend school because of weight gain which was a side effect of the prescribed medication. The Dr. was aware the SC engaged in marijuana and mushroom use and her refusal to venture out of the home.

On 6/10/19, the pediatrician, who provided care to the SC from birth, told the Specialist the SC had a chronic condition that was under control. The SC had been hospitalized at NYU multiple times related to her medical condition. There was a

gap in her medical insurance from 2014 to 2017. The SC was non-compliant with visits; her last exam occurred on 3/18/19; however, the SC did not return for a follow up and last emergency room visit was in August of 2018. The pediatrician suspected the SC was "taking something," but when asked, the SC denied engaging in illegal substances.

On 8/6/19, the ME listed the cause of the SC's death as multiple drug intoxication (Fentanyl, Acetyl-fentanyl, Heroin, Phencyclidine, Gabapentin, Diazepam and Clonazepam) and the manner, an accident.

The collateral contacts described the family as nice people and had not seen LE or heard any disturbances from the family's home. It appeared the SM made no attempts to seek medical assistance or to enroll the SC into a drug treatment program as she did in the past to treat the alcohol abuse.

On 9/24/19, ACS substantiated all allegations of the SC by the SM and MGM of the 5/23/19 report citing the report from the ME, the SC's medical and mental history and the knowledge of the family and professionals that the SC was vulnerable.

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:
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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:
There are no surviving minor siblings or other children in the home.

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: 05/23/2019 **Time of Death:** 04:03 PM

Time of fatal incident, if different than time of death: 03:00 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 03:00 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? 3 Hours
At time of incident supervisor was: Not 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	Adult Sibling	No Role	Female	19 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	50 Year(s)
Other Household 1	Adult Sibling	No Role	Female	24 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	67 Year(s)

LDSS Response

On 5/23/19, at 4:03 PM, the SC was pronounced dead by FDNY Paramedic in her home. ACS' Brooklyn Field Office received information from LE that confirmed the death of the sixteen-year-old. On 5/24/19, the ACS Specialist visited the home and initiated an interview with the SM; however, the SM was too distraught to complete the interview. ACS learned there were no other children in the home.

On 5/30/19, the Specialist re-interviewed the SM along with the MGM and AS2. The SM and BF had a relationship filled with DV before he relocated. The SM reported that on the day of the incident, she and the SC ate breakfast together in the

home at 10:30 AM. The SC returned to her bedroom and the SM left home to run errands. The SM returned home at 1:00 PM to find the SC doing fine. At 3:00 PM, the SM checked the SC's bedroom and observed her laying on her bed; she appeared blue in color and there was excretion around her mouth. The SM yelled for assistance and the AS2, who was upstairs, responded and contacted 911 for medical assistance. The MGM was visiting the SM and had fallen asleep in the living room when she heard the cry for help. The AS2 and MGM placed the SC on the floor and attempted resuscitation efforts instructed by the operator.

On 6/21/19, LE reported they removed from the home, a plastic bag and a blender that contained residue of Heroin, Fentanyl and Tramadol. LE closed their case.

According to ACS documentation, the SM and SC had incidences where they had engaged in drug/alcohol abuse in the past. Prior to her death, the SC had disclosed she and the SM drank alcohol together and the SM was aware of her drug use. The SM disclosed she placed the SC in a facility after an isolated incident when she was inebriated at a party, passed out and was hospitalized. The SM sought help for the SC at that time. The family received therapy from 5/17/17 to 11/7/17. The services stopped when the SM decided to homeschool the SC. The SC had mental health diagnosis for which she had prescribed medication; however, it is unknown whether the SC followed the medication regiment as prescribed. The SM and the MGM were aware the SC was using drugs and needed closer supervision.

On 7/18/19, the Specialist interviewed the SM, MGM at the case address in addition to the AS1 (who was away at college at the time of the incident). The BM reported she did not know where the SC obtained the illicit drugs; however, she was sure the SC had no visitors that day and she did not leave the home either. The SM refused to submit to drug screening.

ACS learned from AS1 that she and her siblings witnessed DV between their parents when the parents were intoxicated. The AS1 declined grief counseling and returned to live on campus.

On 8/19/19, ACS interviewed the BF and learned that he heard of his daughter's death from someone who contacted him after they saw it posted on social media. Prior to that he had no contact with the SM or the MGM who had reported to him in the past that the children were all well. The BF stated he was not aware of the SC's drug use. He found out the cause of his daughter's death from the AS2 when they both attended an AA meeting. The BF reported he was excluded from the home two years prior to the fatality due to issues surrounding drug use by the SM and AS2. The BF reported the SM slept out most nights and was seldom at home to supervise. The BF stated he believes the SC committed suicide.

ACS substantiated the allegations of DOA/fatality, LS, IG and CD/A of the SC by the SM and MGM. ACS cited the ME report in addition to the results of ACS' investigation that the SM and MGM were aware of the SC's emotional, cognitive and behavioral issues and did not ensure the SC was adequately supervised as she had access to illegal substances in the home. In addition to a blender that was found in the home that contained traces of illegal substances.

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)?No

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not have an OCFS approved CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051908 - Deceased Child, Female, 16 Yrs	051909 - Mother, Female, 50 Year(s)	Lack of Supervision	Substantiated
051908 - Deceased Child, Female, 16 Yrs	051909 - Mother, Female, 50 Year(s)	Childs Drug / Alcohol Use	Substantiated
051908 - Deceased Child, Female, 16 Yrs	051909 - Mother, Female, 50 Year(s)	DOA / Fatality	Substantiated
051908 - Deceased Child, Female, 16 Yrs	051910 - Grandparent, Female, 67 Year(s)	Lack of Supervision	Substantiated
051908 - Deceased Child, Female, 16 Yrs	051910 - Grandparent, Female, 67 Year(s)	Inadequate Guardianship	Substantiated
051908 - Deceased Child, Female, 16 Yrs	051910 - Grandparent, Female, 67 Year(s)	Childs Drug / Alcohol Use	Substantiated
051908 - Deceased Child, Female, 16 Yrs	051910 - Grandparent, Female, 67 Year(s)	DOA / Fatality	Substantiated
051908 - Deceased Child, Female, 16 Yrs	051909 - Mother, Female, 50 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The SM had a history of substance abuse; she had been receiving services from a therapist in the community. The SM will continue to engage in the necessary services. The MGM declined services offered by ACS.

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 are no surviving minor 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 SM was engaged in therapy prior to the fatality and continued to engage in therapy. The MGM declined services.

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)
01/28/2017	Deceased Child, Female, 14 Years	Mother, Female, 48 Years	Childs Drug / Alcohol Use	Unsubstantiated	No
	Deceased Child, Female, 14 Years	Mother, Female, 48 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Female, 14 Years	Mother, Female, 48 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 14 Years	Mother, Female, 48 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The report alleged the SM abused alcohol to the point that it impeded her ability to adequately supervise the fourteen-year-old (SC). The SM was aware the SC used alcohol and pain pills and she passed out while at parties. The SM did not address the SC's behavior. A subsequent report was registered on 1/31/17 that alleged the SC abused alcohol, marijuana, cocaine, Xanax and Percocet to the point of impairment. The SM was aware and failed to intervene.

Report Determination: Indicated | **Date of Determination:** 04/03/2017

Basis for Determination:
ACS substantiated the allegations of IG and PD/AM of the SC by the SM citing the SM tested positive for angel dust.

The allegations LS and CD/A were unsubstantiated citing the result of their investigation reflected the SC denied drug use and tested negative for all drugs and the SC's poor attendance. The SM failed to complete the home-school application process.

OCFS Review Results:
The investigations and their determinations along with the service plan referrals were appropriate.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

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

The SM was known to the SCR and to ACS in one report that occurred more than three years prior to the fatality. In 2008, there was a concern that the AS's educational needs were not being met. ACS investigated and unsubstantiated the allegation of EdN of the AS by the SM. ACS documented that the AS, who was about to turn seventeen-years-old, was refusing to attend school because he was working and was enrolled in a GED program at that time. ACS found no credible evidence to substantiate the allegations against the SM.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Preventive Services History

The family was referred for services during the investigation of the 1/28/17 report. The SM tested positive for an illicit drug and the SC was inebriated and hospitalized. The SM and the SC enrolled in PPRS on 5/3/17 under the auspices of Brooklyn Community Services. The services began on 5/17/17 and they completed the services on 11/17/17. The SM and SC received individual and family drug and alcohol counseling.

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