Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-22-055

Prepared by: New York City Regional Office

Issue Date: Jan 03, 2023

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	DA-District Attorney	
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	SXTF-Sex Trafficking
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
Jurisdiction: Kings
Date of Death: 11/01/2021
Age: 10 month(s)
Gender: Female
Initial Date OCFS Notified: 07/14/2022

Presenting Information

The New York City Administration for Children's Services (ACS) received a report on 7/14/22, regarding the death of the 9-month-old subject child that occurred on 11/1/21. The report alleged that the father had been using drugs on that day and the child was found unresponsive. The father attempted CPR and called 911. The child was transported to the hospital where she was pronounced dead. The cause of death was acute intoxication by the combined effects of fentanyl and heroin. The mother was at work at the time of the child's death and had an unknown role.

Executive Summary

This fatality report concerns the death of a 10-month-old female subject child that occurred on 11/1/21. A report was initially made to the SCR on that same date with allegations of Inadequate Guardianship against the mother and father as well as DOA/Fatality and Parent's Drug/Alcohol Misuse against the father. The initial investigation received on 11/1/21 was unsubstantiated for DOA/Fatality due to a lack of credible evidence that the father's actions or inactions contributed to the child's death. The allegation of Inadequate Guardianship against both the mother and father and the Parent's Drug/Alcohol Misuse allegation against the father were substantiated as the mother was aware the father was an active heroin user, had recently relapsed, and should not have been the sole caretaker for the subject child. New information was received as a result of the final autopsy report, and an SCR report was registered on 7/14/22 regarding the subject child's death. The New York City Administration for Children's Services (ACS) received the report and investigated the child's death.

At the time of the child's death, she resided with her mother and father; however, the father died of an overdose on 4/26/22. There were no siblings or other children in the home. The investigation revealed that on 11/1/21, the mother left the child at home with the father when she went to work. The father used substances during the day while caring for the subject child and took a nap with the child at some point in the afternoon. The record reflected a 911 call was received at 4:25PM and the child was transported to the hospital where she was pronounced dead at 5:38PM.

The final autopsy report revealed the subject child died as a result of acute intoxication by the combined effects of fentanyl and heroin. ACS completed a multidisciplinary investigation into the re-reported death upon receipt of the final autopsy toxicology results. ACS coordinated efforts with law enforcement and learned the death was being considered a homicide. The father was arrested in April 2022 and charged with manslaughter and criminally negligent homicide. The father passed away prior to criminal proceedings.

ACS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, the medical examiner, and relatives. ACS provided fatality-related services to the mother upon receipt of the initial report and the mother was reported to be engaged in community-based services.

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

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 record contained detail of supervisory consultation and appropriate casework and collateral contacts.

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: 11/01/2021 **Time of Death:** 05:38 PM

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

County where fatality incident occurred:	Kings
Was 911 or local emergency number called?	Yes
Time of Call:	04:25 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

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	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	44 Year(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)

LDSS Response

On 7/14/22, ACS received a report regarding the death of the subject child that was previously investigated. ACS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. ACS established there were no siblings, nor were there any other children residing in the home where the fatal incident occurred.

ACS received the medical examiner's report on 7/20/22, which revealed the child's death was the result of acute intoxication by the combined effects of fentanyl and heroin. ACS spoke with law enforcement and learned the death was treated as a homicide and the father was arrested and charged prior to his death. When the father died, he had been bailed out of jail and was awaiting trial for the charges of manslaughter and criminally negligent homicide.

ACS spoke with the mother following receipt of the final autopsy report. The mother confirmed the father was an active heroin user and had relapsed in the days leading up to the child's death. The mother continued to leave the child in his care. The mother does not believe the father intentionally gave the child the drugs that were found in her system at the time of death. The mother reported she was not able to speak to the father about the results of the toxicology as he passed away shortly after his arrest.

ACS substantiated the allegations of DOA/Fatality, Parent's Drug/Alcohol Misuse, Poisoning/Noxious Substances, and Inadequate Guardianship against the father regarding the subject child. ACS determined the father had a history of heroin use and information received reflected he used on the day of the child's death. The father was the caregiver present with the child at the time she ingested the drugs and was arrested and charged in her death. The father died prior to ACS receiving the final autopsy and toxicology report, thus new information could not be addressed with him. ACS did not add or substantiate the allegation of Inadequate Guardianship against the mother despite her acknowledgement that the father was actively using heroin and had relapsed the day prior to the child's death. Despite that awareness, the mother left the child in the father's care on 11/1/21. When the death was previously investigated, ACS substantiated Inadequate Guardianship against the mother, citing the mother was aware the father was using drugs and left the child in his care. ACS was not consistent in determining the investigation with the most recent information.

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 investigations as New York City coordinated efforts with law enforcement and notified the DA's office of the death.

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062103 - Deceased Child, Female, 10 Mons	062104 - Father, Male, 44 Year(s)	DOA / Fatality	Substantiated
062103 - Deceased Child, Female, 10 Mons	062104 - Father, Male, 44 Year(s)	Inadequate Guardianship	Substantiated
062103 - Deceased Child, Female, 10 Mons	062104 - Father, Male, 44 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
062103 - Deceased Child, Female, 10 Mons	062104 - Father, Male, 44 Year(s)	Poisoning / Noxious Substances	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:

The father was unable to be interviewed face-to-face as he passed away prior to receipt of the SCR investigation.

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: Criminally negligent homicide **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Father	Unknown	NA
Comments:	The father was charged with criminally negligent homicide and manslaughter following the receipt of the toxicology report for the subject child. The record did not reflect the date the father was charged. There was no disposition as the father died prior to criminal proceedings.		

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:
Following the death, ACS provided the family with bereavement counseling referrals, as well as information on substance abuse services for the father.

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 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? Yes
Explain:
Following the death, both the mother and father were referred to community-based services related to bereavement and mental health counseling. The mother was engaged in grief counseling at the time the investigation closed.

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

Infants Under One Year Old

During pregnancy, mother:
- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:
- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
11/01/2021	Deceased Child, Female, 9 Months	Father, Male, 44 Years	Parents Drug / Alcohol Misuse	Substantiated	No
	Deceased Child, Female, 9 Months	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	

	Deceased Child, Female, 9 Months	Father, Male, 44 Years	Inadequate Guardianship	Substantiated
	Deceased Child, Female, 9 Months	Father, Male, 44 Years	DOA / Fatality	Unsubstantiated

Report Summary:
An SCR report was received which alleged that on 11/1/21, the father took a one to two hour nap with the nine-month-old subject child in his bed. The father fell asleep with the child on the right side of his chest. The child was face down while laying on top of the father while the father slept. When the father woke, the child was unresponsive and still laying on the right side of the father's chest. The father performed CPR for two minutes prior to calling 911 at 4:26PM. Emergency medical services was unable to revive the child upon arrival and the child was pronounced dead at 5:38PM.

Report Determination: Indicated | **Date of Determination:** 12/31/2021

Basis for Determination:
ACS found credible evidence to support the allegation of Inadequate Guardianship against both parents. ACS determined the mother was aware the father had relapsed on heroin and should not have been a sole caretaker for the subject child. The allegation of Parent’s Drug/Alcohol Misuse against the father was substantiated as the father admitted he used heroin daily to the point of impairment while caring for the subject child. The DOA/Fatality allegation was unfounded as ACS did not find evidence that the father’s placement of the child in bed led to her death.

OCFS Review Results:
Throughout the investigation, ACS spoke with family members and collateral sources. The investigation adhered to previously approved protocols for joint investigations as ACS coordinated efforts with law enforcement and notified the DA's office of the death. The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances and objectives were completed within the required timeframes.

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

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

The father was listed as an unrelated home member with no role on an investigation from 8/23/18.

Known CPS History Outside of NYS

There was no known 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