Child Fatality Report

Report Identification Number: NY-21-116

Prepared by: New York City Regional Office

Issue Date: May 10, 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: 16 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 11/10/2021
Initial Date OCFS Notified: 11/10/2021

Presenting Information

The SCR report alleged the SC had a history of abusing marijuana, cocaine, and alcohol. In June 2021, the SC overdosed on an unknown drug. In August of 2021, the SC drank alcohol to the point of intoxication and overdosed. The BM and the BF were aware of the situation but could not control the SC. As a result, the SC continued to abuse the drugs and alcohol. On 11/10/21, the SC was asleep in the living room. The BF left the home for a period of time and the BM was present in the home with the SC. At approximately 5:30PM, the BF went to wake the SC up and the SC was cold to the touch. The BF called 911 and the SC was transported to the hospital by EMS. The SC arrived at the hospital at 6:15PM. As a result of abusing the drugs, the SC was pronounced deceased on 11/10/21 at 6:55PM.

Executive Summary

This fatality report concerns the death of a sixteen-year-old male SC that occurred on 11/10/21 due to possible drug overdose. The family declined an autopsy due to religious beliefs and the ME ruled that the cause and manner of death were undetermined.

ACS' case documentation reflected on 11/10/21, the SC was sleeping and snoring on his bed throughout the day. At approximately 5:30PM, the BF checked in on the SC and found him unresponsive, and cold to the touch. The BF alerted the BM and the adult sister, who called 911. EMS responded to the home and attempted to resuscitate the SC without success. EMS continued resuscitation efforts on the SC during transport to the hospital where medical staff pronounced him dead at 6:55PM.

At the time of the fatality, the SC resided with his BM, BF, adult sister, and 6-year-old surviving sister.

On 11/10/2021, ACS received the report and commenced the CPS fatality investigation within the mandated timeframe. During the investigation, ACS reviewed the family's prior CPS records and made several collateral contacts including the ME, LE, hospital staff, school staff, service provider, pediatrician, and the family. The information obtained by ACS indicated the SC had ongoing history of substance abuse and received outpatient service; however, he declined recommendations for inpatient treatment. The parents tried their best to ensure that the SC complied with treatment recommendations, but he threatened to take his life. LE did not make any arrest and closed the criminal investigation.

Also during the investigation, ACS assessed the SS for safety through ongoing home and school visits and deemed her safe in the care of her parents. The pediatrician, school staff, and the family's neighbors did not report any concerns for the SS. ACS held a child safety conference, and the outcome was provision of resources for bereavement counseling services to the family by ACS. Consequently, ACS provided the family with referrals to receive services in the community.

On 1/14/2022, ACS UNSUB the allegations of the report due to lack of credible evidence to support the concerns. ACS based its decision on the information obtained from pertinent collaterals and the family which indicated the SC had ongoing history of substance abuse and was non-compliant with services. LE reported that a bag of cocaine was found in the bed next to the SC's body. Also, the hospital staff reported the SC died of possible drug overdose. Additionally, the parents took appropriate measure by contacting emergency services to save the SC's life when they found him unresponsive. The ME ruled the cause and manner of death were undetermined.

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?** 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:
There were no safety concerns observed regarding the surviving sibling.

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: 11/10/2021 **Time of Death:** 06:55 PM

Time of fatal incident, if different than time of death: 05:30 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 05:30 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? No - Not needed given developmental age or circumstances

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	Male	16 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)

LDSS Response

On 11/11/21, ACS visited the family at the case address. ACS was unable to fully engage the family as they were grieving. ACS observed the SS to be free of any injuries. The family's neighbors were unavailable for an interview.

On 11/11/21, LE stated the family reported that they found a small bag of cocaine next to the SC's body in the home. LE did not suspect any criminality regarding the SC's death and would be closing the criminal investigation.

On 11/11/21, the medical staff reported the SC was previously admitted on 8/18/21 for one day due to drug use. The staff stated based on the SC's history of drug and alcohol abuse, his death could probably be from drug overdose. The SC had refused recommended outpatient treatment for substance abuse.

On 11/16/21, the SC's substance abuse counselor reported the SC was non-complaint with services.

On 11/16/21, the school staff did not report any behavioral or educational concerns for the SS. The parents were very active in the SS's educational needs. The SS appeared to be coping and processing the loss of her brother very well.

On 11/16/21, LE stated the attending doctor reported that the SC's death appeared to be from drug overdose. LE did not find any criminality, and there would be no investigation.

On 11/16/21, ACS conducted a follow up visit with the family at the case address. ACS assessed the SS to be safe in the care of her parents. The SS stated she was not fearful of anyone in the home. She denied physical discipline by her parents, and adult sister. The BM reported the SS did not witness the incident as she was in the room sleeping at the time. The family provided a timeline of events on the date of the SC's death which was consistent with the information that was

already known. They reported the SC had a history of using marijuana, cocaine, and alcohol. The family found a bag containing cocaine next to the SC's body when they found him unresponsive in bed. They stated the SC had a pattern of sleeping all day and would not want to go to school. The SC would get upset whenever the parents tried to wake him up. They reported past efforts to ensure the SC got help which included inpatient treatment program, but the SC threatened suicide if he was put in a rehabilitation program. ACS provided the family with bereavement referrals.

On 11/16/21, the ACS worker who previously worked with the family stated the SC abused drugs and alcohol and was not attending school. The parents tried their best to ensure that the SC attended school but could not control the SC's behavior. The worker did not report any concern for the other children in the home.

On 11/19/21, ACS held a child safety conference, and the outcome was continuous provision of resources for bereavement counseling services to the family.

On 11/23/21, the school staff reported poor record of attendance for the SC. The staff worked out a plan with family for the SC to attend school without success.

On 11/23/21, the ME reported the family objected to an autopsy due to their religion and the case was closed out. The cause and manner of death were undetermined.

On 11/23/21, the pediatrician did not report any medical diagnosis for the SS. The SS's immunizations were current.

Between 11/30/21 and 1/11/22, ACS made casework contacts with collaterals and conducted school and home visits with the family. The family were not in any services but reported they received support from the community and were doing okay. ACS assessed and deemed the SS safe in the care of her parents. The collaterals did not report any concerns for the SS since the fatality. The mother of the SC's girlfriend reported her daughter was coping very well and receiving counseling services in school.

On 1/14/2022, ACS UNSUB the allegations of the report due to lack of credible evidence.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060117 - Deceased Child, Male, 16 Yrs	060118 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated

060117 - Deceased Child, Male, 16 Yrs	060118 - Mother, Female, 40 Year(s)	Childs Drug / Alcohol Use	Unsubstantiated
060117 - Deceased Child, Male, 16 Yrs	060118 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
060117 - Deceased Child, Male, 16 Yrs	060119 - Father, Male, 47 Year(s)	DOA / Fatality	Unsubstantiated
060117 - Deceased Child, Male, 16 Yrs	060119 - Father, Male, 47 Year(s)	Childs Drug / Alcohol Use	Unsubstantiated
060117 - Deceased Child, Male, 16 Yrs	060119 - Father, Male, 47 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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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)
07/19/2021	Deceased Child, Male, 16 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 16 Years	Mother, Female, 39 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 16 Years	Father, Male, 47 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 16 Years	Father, Male, 47 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The SC had a significant history of unsafe behaviors and mental illness. In the past, the SC had stabbed another individual with a knife. As a result of the SC's behaviors, he was mandated to attend mental health counseling. However, the SC refused to comply and stopped engaging in treatment. The parents were aware of this past situation; however, they failed to follow through and address the SC's behaviors. As a result, the SC's mental health concerns and behaviors were ongoing.

Report Determination: Unfounded | **Date of Determination:** 09/17/2021

Basis for Determination:
The parents denied knowledge of the SC using drugs and not attending school. During the investigation, ACS visited the family numerous times to monitor and assess the safety of the children in the home. ACS observed that the parents were able to meet a minimum standard of care for the children. There were no safety concerns noted. The parents have enrolled the SC in services for substance abuse and counseling. The SC met with the counselor twice a week and the counselor stated the SC was attempting to meet his goals. The parents were willing to comply with service recommendation and referrals were provided for the family.

OCFS Review Results:
ACS reviewed prior history regarding the family. ACS sought and received the assistance of the investigative and clinical health consultants. Also, there was evidence of supervisory involvement and the caseworker complied with supervisory directives throughout the investigation. NYCRO agrees with the case determination of UNF due to lack of credible evidence to support the concerns reported.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/18/2019	Deceased Child, Male, 14 Years	Mother, Female, 38 Years	Educational Neglect	Far-Closed	No
	Deceased Child, Male, 14 Years	Father, Male, 45 Years	Educational Neglect	Far-Closed	

Report Summary:
The SC had been absent from school 8 days out of 12 days, and he was failing as a result. On 10/18/2019, a FAR referral was made after the SC was not attending his suspension site. He was suspended from his home school as he was caught with a knife at school. The parents shared their concern with the worker about the SC's behavior. They took the SC to therapy in the past, but the SC did not attend. The BF stated he was willing to relocate the family if the SC did not feel safe in the neighborhood and felt he had to carry a knife, but the SC stated he would not relocate with the family.

OCFS Review Results:
The FAR worker utilized the FAR tools to illicit information about the family, and completed the Family Led Assessment Guide with the family. ACS engaged the SC around the reasons of him carrying a knife and he did not provide an answer. ACS provided counsel around carrying a weapon and being involved in illegal activities. The SC's behavior improved in the home was attending school more consistently. ACS provided the parents with information regarding PINS warrant and the Family Assessment Plan program for future utilization.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/07/2018	Deceased Child, Male, 13 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	No

Deceased Child, Male, 13 Years	Mother, Female, 36 Years	Lack of Medical Care	Unsubstantiated
Deceased Child, Male, 13 Years	Father, Male, 44 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 13 Years	Father, Male, 44 Years	Lack of Medical Care	Unsubstantiated

Report Summary:
The SCR report alleged in December 2017, it was discovered that the SC was self-harming by cutting his forearm. The parents were given a referral to take the SC for counseling and he failed to follow through. As a result, the SC continued to self-harm.

Report Determination: Unfounded **Date of Determination:** 07/09/2018

Basis for Determination:
The parents sought medical advice from a family doctor who informed the parents that the SC was well and did not need services. The parents believed that the SC was better especially since he had stopped cutting himself. When it was brought to the parents' attention by the school that the SC was involved in possible theft and self-harming, the BF took the SC to the school to address the matter. The BF conducted family sessions with the children about self-harming and other negative behaviors. ACS referred the family to community-based services. The parents also agreed to necessary supervision of the SC to ensure that he did not revert to harming himself.

OCFS Review Results:
ACS initiated the investigation timely and made the appropriate collateral contacts. ACS' determination of UNF was consistent with the investigation findings.

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

The family did not have any known CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No