Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-20-028

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

Issue Date: Nov 24, 2020

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: Westchester
Gender: Male
Date of Death: 06/18/2020
Initial Date OCFS Notified: 06/18/2020

Presenting Information

An SCR report received alleged that the subject child had mental health issues. The child attempted suicide a year prior to his death and had not received mental health treatment or taken medication for depression. The subject child continued to have mental health issues and the mother failed to obtain mental health treatment for him. The mother last saw the subject child at 7:00PM on 6/17/20 and found him at 7:45AM on 6/18/20 in cardiac arrest. The mother contacted 911 and was provided instruction on how to perform cardiopulmonary resuscitation. Emergency medical services arrived, the subject child was in cardiac arrest, they continued cardiopulmonary resuscitation and the subject child was transported to the hospital where he was pronounced deceased between 8:45AM and 9:00AM. The subject child had no other medical conditions, there were no visible injuries and the cause of death was unknown. The mother provided no explanation for the child's death.

Executive Summary

On 6/18/20, the Westchester County Department of Social Services (WCDSS) received an SCR report regarding the death of the 16-year-old subject child. At the time of his death, the child resided with his mother, and two siblings, ages 7 and 15 years old.

WCDSS conducted a joint investigation with law enforcement and learned that on the evening of 6/17/20, the mother gave the subject child dinner around 5:00PM. The subject child took his dinner into his bedroom and the mother did not see the child for the remainder of the night. At approximately 7:45AM the following morning, the mother went to check on the child and discovered him unresponsive. The mother instructed the 15yo sibling to call 911 and the mother was provided direction on CPR. When first responders arrived, the mother was performing CPR. First responders administered life saving measures on the scene, including Narcan, and transported the subject child via ambulance to the emergency room. Resuscitative efforts continued at the hospital until the subject child was pronounced deceased by emergency room staff.

An autopsy was performed, and the final report was pending at the time this report was written. Toxicology results were not yet available but a preliminary report showed that the subject child may have overdosed from Fentanyl. Law enforcement did not find drug paraphernalia in the child's bedroom. There was a Hookah dispenser present. At the time the CPS investigation was closed, law enforcement had not pursued any criminal charges.

WCDSS interviewed the family and assessed the home environment. The interviews focused on the allegations in the SCR report and did not address overall safety and risk. It was not documented there were attempts made to interview the fathers or that they were notified of the SCR report. The siblings' safety was assessed throughout the investigation and there were no concerns expressed for their care. WCDSS provided the mother and siblings with a referral to a victim's assistance program.

There was sufficient information gathered by way of collateral and casework contacts to substantiate the allegations against the mother. The child required and was referred for outpatient mental health services, including addictions counseling treatment and medication management in the past. The mother did not follow through with the recommendations. WCDSS conferenced with their legal department regarding mandatory prevention services; however, it was determined the siblings did not have needs that warranted continued child welfare involvement. The CPS investigation was indicated and closed on 8/17/20.

PIP Requirement

This review resulted in a citation related to casework practice. In response, WCDSS will submit a PIP to the Westchester 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

Casework activity was commensurate with case circumstances.

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:

WCDSS documented a legal case conference in which mandatory ongoing services were discussed. It was determined that the siblings did not have any mental health or behavioral concerns that necessitated ongoing services and therefore they were not pursued.

Required Actions Related to the Fatality

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

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.

Summary:	The 30-Day Fatality Report was due on 7/18/20; however, was completed on 8/15/20 and approved on 8/17/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The 30-day Fatality Report must be documented in a template in Connections within 30 days of the receipt of a report alleging the death of a child because of abuse or maltreatment
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-day fatality safety assessment was due on 7/18/20; however, was completed on 8/14/20 and approved on 8/17/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	WCDSS must complete a safety assessment at 30 days for reports of a child fatality, unless there are no surviving siblings or children in the household. This is in addition to the 24-hour assessment, the initial seven-day assessment and the conclusion safety assessment that must be completed within seven days prior to closing the case.
Issue:	Failure to Provide Notice of Indication
Summary:	The case record did not reflect that the mother was provided with a notice of indication.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	If determined, within 60 days, whether a report assigned to the investigative track is "indicated", WCDSS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.
Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The record did not reflect that there were attempts made to interview the fathers of the children or notify them of the SCR report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/18/2020 **Time of Death:** 08:45 AM (Approximate)

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? Unknown

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	Deceased Child	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)

LDSS Response

On 6/18/20, WCDSS received the report from the SCR and they coordinated efforts with law enforcement. They notified the DA's office about the fatality and they gathered additional information from emergency medical services and the medical examiner's office.

WCDSS conducted a home visit, and they interviewed the mother and 15yo sibling. The 15yo sibling reported her relationship with her brother was not close and therefore she was not able to contribute any information related to his mental health or well being. There were multiple attempts made to engage the 7yo sibling in the interview process, which were refused by the sibling. ECDSS determined the siblings were safe in their mother's care.

The mother reported that she last saw the subject child alive around 5:00PM on 6/17/20. The mother gave the subject child dinner and he took the food back to his bedroom where he remained until the mother found him unresponsive the next morning. The mother was certain that the subject child did not leave the house at any point during the night. The mother found the child unresponsive around 7:45AM on 6/18/20, when she went to check on him prior to leaving for work. While in the child's bedroom, the mother reached for her phone charger and reported her hand made contact with the child's hand and she noticed that it was cold. She then noticed that he appeared pale with his mouth and eyes slightly open and his eyes rolled to the back of his head. The mother requested that the 15yo sibling call 911 and the mother was provided instruction for CPR over the phone.The mother described finding the subject child on his back and twisted to the side. The family described him as a healthy teenager with no medical concerns.

WCDSS inquired about the subject child's drug or alcohol use and behaviors leading up to his death. The mother stated that she was not aware of any drug use by her son but was aware of him smoking hookah. The mother reported a few days prior to the fatality, the subject child was observed to be jittery and not himself. The day prior to his death the mother reported no concerns for the child. The subject child had gone out with his friends, which was typical for him.

WCDSS gathered information regarding the subject child's mental health through casework and collateral contacts. It was learned that subject child was admitted to a psychiatric facility in 2019 due to attempted self harm. He was diagnosed with Unspecified Depressive Disorder and Mild Cannabis Use Disorder. It was recommended the subject child engage in a Mentally Ill Chemical Addiction (MICA) treatment program and he was prescribed a 30-day medication. WCDSS questioned the mother about the recommendation and medication and it was determined the mother had not arranged for the subject child's ongoing treatment and medication management.

First responders reported that the mother was performing CPR on the child when they arrived. Law Enforcement did not observe any signs that the subject child had self harmed and there was only a hookah dispenser discovered in the bedroom. The medical examiner determined that there was nothing lodged in the child's throat, and there was no trauma to the child's body. The preliminary report showed that the child may have overdosed on Fentanyl, but toxicology results were pending at the time the CPS investigation closed. The pediatrician reported no concerns for the childrens' care.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: Within 24 hours of the SCR report, WCDSS contacted law enforcement and the district attorney's office regarding the fatality.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: Westchester County DSS indicated in their 24-hour fatality report the fatality would be referred to their county's CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054549 - Deceased Child, Male, 16 Yrs	054550 - Mother, Female, 39 Year(s)	DOA / Fatality	Substantiated
054549 - Deceased Child, Male, 16 Yrs	054550 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
054549 - Deceased Child, Male, 16 Yrs	054550 - Mother, Female, 39 Year(s)	Lack of Medical Care	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:

There were efforts made to interview the 7yo sibling; however, he was unwilling to speak with CPS about the death, or participate in an interview.

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	☐	☐	☐	☐	☐	☒	☐

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:
The surviving siblings were provided with referrals to a victim's assistance program.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was provided with a referral to a victim's assistance program.

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)	Status/Outcome	Compliance Issue(s)
05/30/2019	Deceased Child, Male, 15 Years	Mother, Female, 38 Years	Educational Neglect	Far-Closed	Yes
	Deceased Child, Male, 15 Years	Mother, Female, 38 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report alleged that the mother was overwhelmed and frustrated with the then 15-year-old subject child and his education. The mother was not able to control the child and he missed 17 days of school. The child was failing tenth grade and had to repeat five classes. The child went to school late and was skipping classes throughout the day. The mother was aware of the absenteeism, as she had received letters, meeting requests and phone calls from the school and had not responded.

OCFS Review Results:
WCDSS tracked the SCR report as CPS FAR after options were thoroughly reviewed with the mother. WCDSS utilized FAR tools and questions to engage and work in partnership with the family to address safety concerns. Safety was accurately assessed, service needs were identified and referrals for services were made. The mother provided WCDSS with the phone number for the father of the now 7yo sibling. There was no documentation that WCDSS made efforts to

contact the 7yo sibling's father to make him aware of the SCR report or obtain contact information for the other absent father.

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

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:
The mother provided the names of the children's fathers and contact information for one of them; however, the record did not reflect there was attempted contact made or additional efforts to obtain locating information.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:
Family assessment response workers must work in partnership with the families participating in a family assessment response. Workers should be transparent with families regarding all actions that they take regarding the case. To the extent feasible, child protective service workers should include all family members in discussions.

[redacted]

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