NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-15-004 **Prepared by: Buffalo Regional Office**

Issue Date: 2/12/2016

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
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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 01/21/2015
Initial Date OCFS Notified: 01/26/2015

Presenting Information

On 1/21/15, while the BM was taking a nap, the SC got into the BM's fentanyl patches. When the BM awoke she found the SC unresponsive with purple lips. When the BM attempted CPR she found a fentanyl patch in the SC's mouth. The SC was unable to be revived and was pronounced dead at 12:21 p.m.

Executive Summary

The autopsy report lists the cause of the death of the 16 year old SC as Acute Mixed Drug Intoxication including Fentanyl, Oxycodone, Doxylamine, Lamotrigine, Pregablin, Amitriptyline, Citalopram, Alprazolam, and Dextromethorphan. The manner of death was listed as Accident. The ME report stated that SC was pronounced dead after being found unresponsive with a fentanyl patch in her mouth. The examination revealed no physical abnormalities. The SCR report was made on 1/23/16 with allegations of DOA/Fatality and IG against the BM.

There were no surviving children in the SC's household. The CW did a complete investigation including interviewing the subject and all other persons named in the report. The CW spoke with the police, EMS and the Emergency Room personnel. The CW also spoke to the psychiatrist and counselors as well as both the SC's Dr and the BM's Dr. Per multiple collaterals, BM acted appropriately with obtaining appropriate treatment for SC for her addiction and mental health concerns. It was determined that SC broke into the locked lock box where the medications were kept and took a Fentanyl patch and other medication prescribed to her BM. The report was unfounded on 3/23/15 and the case was closed with no further CPS intervention required. Grief counseling information was provided to all parents involved.

The CW documented all collaterals and interviews in a timely manner with appropriate detail. The case record contained all necessary medical and supporting documentation. All safety assessments were done on time and the report was determined within 60 days.

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?** 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:
The CW did an excellent job of collecting appropriate information and documenting such.

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:
Case was unfounded and closed. The family was referred to grief counseling. No services were needed.

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: 01/21/2015 **Time of Death:** 01:04 PM

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

County where fatality incident occurred:	ERIE
Was 911 or local emergency number called?	Yes
Time of Call:	12:27 PM
Did EMS to 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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age

Deceased Child's Household	Deceased Child	Alleged Victim	Female	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	38 Year(s)
Other Household 1	Father	No Role	Male	49 Year(s)
Other Household 2	Other Adult	No Role	Male	45 Year(s)

LDSS Response

An SCR report was received two days after the death of SC. Upon receipt of the report, 1/23/15, the CW called the source who confirmed the contents of the report. The CW reviewed the CPS history and found that there were other unfounded reports against the BM involving parent's misuse of alcohol and substance abuse. The CW contacted the SC's MH provider who stated that the SC had a long history of drug and alcohol use. The SC was involved with AA and NA. The SC was experiencing a lot of sadness and self harming behaviors. The SC was encouraged by an older sibling's GF to prostitute herself on Craig's list. Charges were bought against the GF and the SC had to testify in front of the grand jury a month before she was found dead. The SCR report was given to the DA. The SC was on medication for depression and anxiety. The CW contacted the Kenmore PD detective. The Detective stated he responded to the call and when he arrived the officers were performing CPR until EMS arrived and took over. The SC was found on her bed with a fentanyl patch in her mouth. The BM was prescribed fentanyl for back pain and the detective observed the locked box under the BM's bed. The detective further stated that the SC often took other people's pills and had overdosed in the past. The CW contacted the ME, the ER and EMS. The CW interviewed the BM who stated that the SC came home about 8:30 am on 1/21/15 from visiting her step-father. The BM had gone back to bed because she was in pain. The SF was awake in the home until 10:30 am when he left for the gym. Before the SF left the SC stated she was experiencing hip pain and wanted to be checked out by a doctor. At 12:21 pm, the BM awoke and went into the SC's room to wake her up for a counseling appt. The BM found the SC on her bed and her lips were purple. The BM immediately called 911 and was instructed to start CPR. When the BM started mouth to mouth she found a fentanyl patch in the SC's mouth. The BM's and the SC's medication was kept in a locked box under her bed. The BM stated that the SC must have broken into the locked box and taken a patch out. The BM stated the SF kept the key on his person. The CW observed the locked box under the BM's bed. The locked box had a key as well as a keypad. The BM did not believe that the SC's death was suicide, she believed that the SC was trying to block out the pain before going to counseling. No note was found suggesting the SC's death was a suicide. The CW also spoke to the SF and SF's father. The SF's father stated that he did not live in the home but was spending a couple of days. The SF's father stated he did not see the SC the morning of her death but was awakened by the BM's screaming. The SF stated that he left the home about 10:30 am and had the key to the lock box on him. The SF received a call about 12:20 p.m. from the BM, screaming that the SC was dead. The CW gave referrals to the family for grief counseling.

The CW contacted the ER and was told the SC arrived at Kenmore Mercy Hospital at 12:53 unresponsive. There was no response from therapy and the SC was in full cardiac arrest. The SC was pronounced dead at 1:04 pm on 1/21/16. The CW spoke to the EMS who stated that the SC was in full cardiac arrest when they arrived. The CW also contacted the SC's Dr who stated that the SC had been in and out of drug rehab multiple times. The Dr stated that the BM always tried to give the SC appropriate care. The CW spoke to the SC's MH counselor who stated that SC never had any suicidal ideations. The CW also spoke to the BM's Dr. and found out that she was prescribed many opiate based meds along with Fentanyl patches. The CW spoke to the school counselor who stated that the SC had not been in the school since 9th grade and was on home instruction. The CW interviewed the Stepfather who stated the BM tried to watch the SC closely. The night before he and the SC stayed home and there was no mention of suicide.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
023741 - Deceased Child, Female, 16 Yrs	024022 - Mother, Female, 44 Year(s)	DOA / Fatality	Unsubstantiated
023741 - Deceased Child, Female, 16 Yrs	024022 - Mother, Female, 44 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?	☒	☐	☐	☐
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	Needed but not Offered	Needed but Unavaliable	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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The CW referred the family to grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/25/2012	7032 - Deceased Child, Female, 13 Years	7031 - Mother, Female, 42 Years	Inadequate Guardianship	Far-Closed	No
	7032 - Deceased Child, Female, 13 Years	7031 - Mother, Female, 42 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
Report alleged that BM was misusing alcohol and not attending to the SC's needs. The BM was sober and had been attending AA for many years and acted as a sponsor for other alcoholics. The SC was on many medications due to her extreme anxiety. The SC was attending one class as prescribed by the Dr. SC was engaged in counseling and there was no need for services. The FAR case was closed on 4/9/12.

OCFS Review Results:
No compliance issues

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)
09/12/2012	7036 - Deceased Child, Female, 13 Years	7033 - Mother, Female, 42 Years	Parents Drug / Alcohol Misuse	Unfounded	No

7036 - Deceased Child, Female, 13 Years	7033 - Mother, Female, 42 Years	Inadequate Guardianship	Unfounded
7036 - Deceased Child, Female, 13 Years	7035 - Mother's Partner, Male, 36 Years	Inadequate Guardianship	Unfounded
7036 - Deceased Child, Female, 13 Years	7035 - Mother's Partner, Male, 36 Years	Parents Drug / Alcohol Misuse	Unfounded

Report Summary:
An SCR report was called in on 9/12/12 with allegations of drug misuse and DV against the BM and SF. The report alleged that the adults were having physical altercations and smoking marijuana in front of the SC. All parties denied the allegations. During the investigation, it was learned that the SC had behavioral issues with anxiety , depression and panic attacks. SC had used opiates and marijuana. The BM responded appropriately to the SC's needs. The SC was in MH and SA counseling. The SC's behaviors were escalating and the CW referred the family to WRAP around services. The report was unfounded on 11/30/12.

Determination: Unfounded | **Date of Determination:** 11/30/2012

Basis for Determination:
There was no credible evidence that the BM and SF were using drugs or fighting in front of the SC. The BM was attending AA and had been sober for 9 years. The collaterals that were contacted including the BF who did not have any issue with the care of the SC. They all reported that the BM acted appropriately in getting services to the SC. All medication was in a locked lock box. The report was unfounded and the family was referred to WRAP around services.

OCFS Review Results:
No recommended or required actions

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)
01/09/2013	7039 - Deceased Child, Female, 14 Years	7037 - Mother, Female, 43 Years	Educational Neglect		No
	7039 - Deceased Child, Female, 14 Years	7037 - Mother, Female, 43 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The SCR report alleged that the SC had been absent from school from 12/21/12-1/9/13. The report stated that the SC was smoking marijuana over the Christmas break. The allegations of educational neglect and IG were alleged against the BM. According to the report, the BM was told by the SC's psychiatrist to keep the SC home due to her high anxiety level. The SC was labeled as ED and the BM did not give the school any medical documentation from a MH professional.

Determination: Unfounded | **Date of Determination:** 02/28/2013

Basis for Determination:
The mother obtained appropriate documentation stating that the SC would be out of school due to extreme anxiety. By the end of the report the SC was attending one class per day. WRAP around services were started. The SC received tutoring, individual and group MH counseling. All collaterals were contacted. The school stated that the BM met all the requirements and was appropriate with the SC's educational needs.

OCFS Review Results:
The CW determined safety within 24 hours, contacted all collaterals and offered appropriate services.

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

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

There were 4 SCR reports between 2010 and 2011. Two of the reports contained allegations of IG and PD/AM against the SM and St F. These were all unfounded due to the SM and SF being sober upon visits. The SM confirm that she is an Alcoholic but had been sober 9 years. She attends AA and is a sponsor for others in the program. The SF also had been clean from drugs since his last jail sentence. The mother was prescribed medication for a disabling back problem. The other 2 SCR reports were for EdN against the SM. The SC had difficulty going to school due to anxiety. The SC was being treated by a Dr. for this and was kept out of school as a result. One case was referred to FAR and the other was unfounded due to the fact that SM was seeking appropriate treatment for the SC.

Known CPS History Outside of NYS

none known

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

Preventive services were provided to the SC and BM from 3/07/2013-10/6/14. These services were started by the referral of the SC's mental health counselor. The SC was experiencing anxiety and was having trouble maintaining her sobriety. She was engaging in delinquency behavior such as: physical aggression, verbal abuse, sexually acting out, damaging property, running away and truancy. The SC was dependent on prescription medication and marijuana. At the time of the referral to preventive services the SC was on home instruction due to her behavior in school. At the end of the case, the SC was attending a day school program; had been sober 8 months and was not a risk of out of home placement or hospitalization. The case was closed on 10/6/14, the only service remaining was mental health counseling.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child’s siblings, and/or the other children residing in the deceased child’s household at the time of the fatality.

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