Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-20-013

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

Issue Date: Oct 13, 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: 14 year(s)
Jurisdiction: Rensselaer
Gender: Female
Date of Death: 05/12/2020
Initial Date OCFS Notified: 05/13/2020

Presenting Information

The death of the 14-year-old female teen was reported to OCFS by the Rensselaer County Department of Social Services through the required 7065 Agency Reporting Form. The teen passed away in the hospital on 5/12/20, after being found unresponsive in her home on 5/11/20.

Executive Summary

On 5/12/20, Rensselaer County Department of Social Services (RCDSS) was notified by hospital staff that the 14-year-old teen had been declared brain dead on that date and that her time of death was 10:15 PM. RCDSS had an open CPS investigation at the time, which was received on 5/11/20, with concerns the teen became unresponsive after drinking alcohol the night prior. The teen resided with her mother and her 18-year-old sibling. The mother's partner was frequently at the home and he was present on the night of the incident. The teen had not had contact with her father for several years.

RCDSS coordinated with law enforcement to investigate the incident that lead to the child's death. It was learned that on the night of 5/10/20, the teen was spending time with her adult sibling and the teen consumed several shots of whiskey before going to bed. At 5:30 AM on 5/11/20, the mother heard noises coming from the teen's bedroom. When she entered the bedroom, the teen was convulsing on her bed. The mother called 911 and just prior to EMS arriving, the teen stopped breathing. Life saving measures were performed and the teen was transported to the hospital via ambulance. The teen was hospitalized and on a ventilator until being declared brain dead on 5/12/20.

An autopsy was performed, and it was determined the teen's death was caused by diphenhydramine and ethanol polypharmacy and overdose. The autopsy report stated that the high level of diphenhydramine in combination with ethanol was sufficient for causing respiratory suppression resulting in global anoxia to vital organs. Law enforcement closed their investigation with no charges filed.

RCDSS contacted numerous collaterals and determined the child's death was not caused by abuse or maltreatment by a caretaker. The adult sibling was determined not to be a person legally responsible for the teen and the mother and her partner were unaware that the teen drank alcohol or took diphenhydramine on the night of the incident. RCDSS referred the family for grief counseling services and they closed the case once all required casework was completed.

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?** N/A

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
RCDSS thoroughly investigated the teen's death and determined it was not the result of abuse or maltreatment of a caretaker.

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:
RCDSS closed the case once they gathered the facts surrounding the teen's death.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/12/2020 **Time of Death:** 10:15 PM

Date of fatal incident, if different than date of death: 05/11/2020
Time of fatal incident, if different than time of death: 05:30 AM

County where fatality incident occurred: Rensselaer
Was 911 or local emergency number called? Yes
Time of Call: 05:40 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☒ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 5 Hours
At time of incident supervisor was:

☐ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☒ Asleep

☐ Distracted
☐ Impaired by disability
☐ Impaired by illness
☐ 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	Adult Sibling	No Role	Female	18 Year(s)
Deceased Child's Household	Deceased Child	No Role	Female	14 Year(s)
Deceased Child's Household	Mother	No Role	Female	48 Year(s)
Other Household 1	Mother's Partner	No Role	Male	49 Year(s)
Other Household 2	Father	No Role	Male	57 Year(s)

LDSS Response

RCDSS thoroughly investigated the facts and circumstances surrounding the teen's death. They interviewed the mother, mother's partner, adult sibling and the teen's father. RCDSS conducted home visits and determined the home environment was free from safety hazards. RCDSS notified the DA's office and OCFS of the teen's death as required.

The mother, her partner and the adult sibling reported that on the night of 5/10/20, the teen and adult sibling visited their grandmother and they returned home around 9:45 PM. They had dinner and hung out in the sibling's bedroom. After the mother and her partner went to bed, the teen and sibling went for a drive. The teen asked the sibling to bring her to a friend's house and she returned to the car with a bottle of whiskey. They got home at 12:30 AM and they watched television in the sibling's bedroom. The teen went to her bedroom and came back 10 minutes later and reported she had taken 3 shots of whiskey. The sibling reported that she yelled at the teen for drinking and the teen was acting a little tipsy but not intoxicated. They hung out in the sibling's bedroom until around 2:30 AM when the sibling went to bed. The mother woke up for work around 5:30 AM and she heard a repetitive banging sound coming from the teen's bedroom and she thought it was the cat making the sound. When she opened the bedroom door, the teen was laying on her side on the bed and she was shaking and making sounds. The mother ran to get her partner and she called 911. The adult sibling was woken up by the mother yelling that the teen was having a seizure.

The mother and sibling reported that the teen was healthy, and they denied that the teen ever had a seizure before. They stated that the teen had experimented with alcohol and marijuana in the past and they denied knowledge that she had used any other drugs. The mother reported that she kept diphenhydramine in the home to treat her allergies.

The father was spoken to on the phone and he confirmed he had not seen the teen in 5-6 years. The mother informed him of the incident, and he had no direct knowledge of what occurred.

First responders reported that they found a diphenhydramine pill on the teen's bed and a vape pen in the teen's sports bra. The toxicology screen performed at the hospital was negative for all substances except alcohol and it was unknown what caused the teen to go into cardiac arrest throughout her hospitalization. Hospital records showed the teen did not regain consciousness and she was declared brain dead on 5/12/20 and subsequently removed from the ventilator.

During the autopsy it was discovered that the teen had a very high level of diphenhydramine in her system and she had a large amount of undigested diphenhydramine in her stomach.

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: Other physician

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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?	☐	☒	☐	☐

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was referred for grief counseling services.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

05/11/2020	Deceased Child, Female, 14 Years	Adult Sibling, Female, 18 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 14 Years	Adult Sibling, Female, 18 Years	Childs Drug / Alcohol Use	Unsubstantiated	

Report Summary:
An SCR report alleged on the morning of 5/11/20, the 14-year-old teen stayed up until 2:30 AM with the 18-year-old sibling. The 18-year-old gave the teen alcohol to consume and throughout the night into the early morning they had four shots of whiskey.

Report Determination: Unfounded | **Date of Determination:** 07/30/2020

Basis for Determination:
The allegations were unsubstantiated due to a lack of credible evidence that the adult sibling provided the teen with alcohol or that she drank alcohol with the teen. It was further determined that the adult sibling was not a person legally responsible for the teen.

OCFS Review Results:
RCDSS conducted a thorough investigation into the incident and the teen's subsequent death by interviewing the family and contacting numerous collateral resources. RCDSS established the teen's death was not the result of abuse or maltreatment of a caretaker.

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

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

There is no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no 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