Child Fatality Report

Report Identification Number: SV-22-001

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

Issue Date: Jul 08, 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
Jurisdiction: Dutchess
Date of Death: 01/16/2022
Age: 14 year(s)
Gender: Male
Initial Date OCFS Notified: 01/16/2022

Presenting Information

Dutchess County Department of Community and Family Services (DCDCFS) received an SCR report that alleged on 1/16/2022 at approximately 10:28am, the mother called 911 after she discovered the 14-year-old male subject child not breathing. The mother performed cardiopulmonary resuscitation until emergency medical services arrived. Emergency medical services transported the child to the hospital where he was pronounced deceased. The mother and her partner did not have an explanation for the child's death.

Executive Summary

On 1/16/2022, the Dutchess County Department of Children and Families received an SCR report regarding the death of the 14-year-old male child that occurred on the same day. At the time of the death, the child resided with the mother. The mother's partner was at the home at the time of the incident. There were no surviving siblings or other children in the home.

DCDCFS conducted a joint investigation with law enforcement to gather information regarding the fatality. On 1/16/2022, the subject child was at his home with the mother and the mother's partner. At approximately 10:00AM, the mother tried to wake the subject child and he was unresponsive. The mother called 911 and her partner assisted in getting the subject child off his bed so the mother could perform CPR at the direction of the 911 operator. First responders arrived and the subject child was without a pulse. The subject child was transported to the hospital and pronounced deceased at 11:13AM.

DCDCFS gathered information from first responders and hospital staff who treated the subject child upon his arrival. First responders and medical professionals reported that they did not observe any obvious cause of death or any injuries and trauma to the subject child's body that would have contributed toward his death. Hospital personnel reported upon arrival to the hospital, the subject child was warm and rigor mortis had not set in, indicating the fatal incident occurred 1 to 2 hours prior to his arrival. There was a large amount of blood in the subject child's esophagus, which the hospital described as abnormal. An autopsy was performed and the results were obtained by DCDCFS. The cause of death was acute xylazine and fentanyl intoxication and the manner was accidental. At the time this report was written, there had been no criminal charges filed related to the child's death.

DCDCFS contacted collateral sources throughout the investigation, including the school and the pediatrician. School staff reported the child was suspended for the entirety of the school year beginning in November 2021 due to fighting. They had no concerns for the mother and described her as very involved and supportive. The subject child was not known to misuse drugs, though there was an incident when he came to school with his bookbag smelling of marijuana. The pediatrician reported the subject child was up to date medically and there were no concerns he misused drugs.

DCDCFS determined there was no evidence to support that there was abuse or neglect against the subject child by the mother or mother's partner that contributed to his death. The mother and collateral sources reported no knowledge as to how the subject child would have come into possession of the substances in the toxicology report. The subject child was discovered smoking marijuana while in his father's care a week prior to the death; however, there were no other concerns reported for his substance misuse. The mother's partner and father of the subject child were minimally cooperative to outreaches made by DCDCFS. The family was offered grief counseling services, mental health counseling and funeral assistance. The CPS investigation was unfounded and closed on 3/15/2022.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
    - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Casework activity was commensurate with case circumstances. DCDCFS determined the allegations based on the evidence gathered.

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 surviving siblings or other children in the home.

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: 01/16/2022 **Time of Death:** 11:13 AM

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

County where fatality incident occurred:	Dutchess
Was 911 or local emergency number called?	Yes
Time of Call:	10:28 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
- [x] 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? 12 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- [ ] Distracted
- [ ] Absent
- [ ] Asleep
- [x] Other: **Watching television**

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	14 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	33 Year(s)
Other Household 1	Father	No Role	Male	32 Year(s)

LDSS Response

Upon receipt of the SCR report on 1/16/22, DCDCFS initiated their investigation and coordinated efforts with LE, conducted a CPS history check, interviewed the family, and offered services regarding the fatality.

DCDCFS and LE completed a joint interview with the SM. The SM last saw the SC in his bedroom on 1/15/22 at 9:30PM prior to going to sleep. On 1/16/22, the SM woke up at 8:00AM and watched television until 10:00AM. The SM went to wake the SC so they could make breakfast together and he was in bed and unresponsive. The home was equipped with indoor motion detected video cameras, and the SM showed DCDCFS and LE the footage from the night prior to the death. Some of the images were not clear and the SM described what was happening as she played the footage. At 2:59AM, the SC walked into the kitchen and pulled what the SM said was a box of cereal out of the cabinet. The SC leaned over to pick something up, which the SM said was a water bottle from where they were stored. At 8:44AM, the SM walked into the kitchen and put food away that was left out the night prior. The SM was next seen at 10:23AM, on her phone running in and out of the kitchen in an erratic state.

DCDCFS gathered information from first responders. LE received a 911 call at 10:28AM regarding the SC. They arrived to the home at 10:32AM and the SM's partner was waiting for them at the door, urging them to hurry to tend to the SC. The SC was laying on the floor and the SM was performing CPR. The SM was inconsolable. EMS performed CPR for approximately 30 minutes at the home before transporting the SC to the hospital. LE searched the home and found rolling papers in the SC’s dresser drawer, along with what appeared to be remnants of a marijuana or tobacco cigarette.

DCDCFS interviewed neighbors who reported concerns for the SM's verbal abuse of the SC, including using derogatory

language toward him. In addition, a neighbor reported that they had previously heard the mother hitting the SC; however, did not hear any hitting noises the month leading up to the death or the night prior. When these concerns were addressed with the SM, she stated the SC was sometimes loud while playing video games and one time punched his computer screen. In addition, the SM reported she was a generally loud person but denied any other disturbances coming from her home or that she used physical discipline. The property manager confirmed complaints regarding marijuana use, noise, various unpermitted male guests, and the SM speaking poorly to the SC.

The SM’s partner reported he did not reside in the home but visited and was present at the time of the death. The SM’s partner reported no concerns for the SC the night prior to him being found unresponsive. He further stated that when the SM discovered the SC, he assisted in getting the SC off the bed and began CPR. The initial interview with the SM’s partner did not include questions about overall safety and risk. DCDCFS made additional attempts to interview him, which he did not respond to. DCDCFS attempted to interview the BF at his home and were unsuccessful. The BF was interviewed via telephone. The BF denied the SC smoked marijuana at his home, was unaware of the results of the SC’s toxicology report and was not willing to further discuss the SC due to grieving his death.

DCDCFS inquired about drug misuse and the SM admitted she used marijuana. The SM initially denied drug misuse by the SC. The SM later reported the SC had been caught smoking marijuana while visiting with the BF on 1/10/22. When the SM was notified of this, she retrieved the SC from the BF’s home. The SM stated the marijuana cigarette in the SC's bedroom was hers and she had brought it into the bedroom with her when she went to wake him up. The SM was unaware of how the SC came to be in possession of the substances discovered in the toxicology.

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)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: Dutchess County does not have an OCFS approved child fatality review team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060386 - Deceased Child, Male, 14 Yrs	060387 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
060386 - Deceased Child, Male, 14 Yrs	060387 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
060386 - Deceased Child, Male, 14 Yrs	060388 - Mother's Partner, Male, 33 Year(s)	DOA / Fatality	Unsubstantiated
060386 - Deceased Child, Male, 14 Yrs	060388 - Mother's Partner, Male, 33 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?	☒	☐	☐	☐

Additional information:
DCDCFS attempted face-to-face contact with the father including visits to his last known addresses. DCDCFS interviewed the father via telephone.

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:
DCDCFS offered the mother and father mental health counseling, grief counseling and funeral assistance.

History Prior to the Fatality

Child Information

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

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)
01/08/2021	Other Child - Cousin , Female, 2 Years	Unrelated Home Member, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 13 Years	Unrelated Home Member, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Cousin , Female, 2 Years	Aunt/Uncle, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	

Other Child - Cousin , Female, 2 Years	Aunt/Uncle, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 13 Years	Aunt/Uncle, Female, 33 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 13 Years	Aunt/Uncle, Female, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged that the aunt smoked crack cocaine daily to the point of impairment while caring for the cousins. The drugs and paraphernalia were left accessible to the two cousins. When impaired, the aunt acted belligerent and irate. The aunt yelled and cursed at both cousins and called the younger cousin derogatory names. The aunt hit the younger cousin and on one occasion, the aunt struck the younger cousin on the side of her head with force and his head hit a door. The subject child had access to a gun in the aunt's bedroom.

Report Determination: Unfounded | **Date of Determination:** 03/30/2021

Basis for Determination:
DCDCFS determined through home visits, face-to-face interviews with the family and contact with collateral sources that there was no credible evidence to substantiate the allegations. The aunt appeared sober during face-to-face contacts and denied the allegations. The older cousin reported feeling safe in the home and denied any CPS concerns. The younger cousin was observed to be free of marks or bruises. Collateral sources reported no concerns for the aunt. The CPS investigation was unfounded and closed.

OCFS Review Results:
DCDCFS interviewed the aunt, unrelated home member and older cousin face-to-face. DCDCFS spoke to several collaterals, including the pediatrician, law enforcement, community services, relatives and family friends. DCDCFS requested the aunt take a drug screen, which returned negative. Several visits to the aunt's home were completed and yielded no concerns. DCDCFS documented a phone call with the older cousin's father; however, he was not interviewed face-to-face or provided with written notice of the report. An inquiry regarding the younger cousin's father was not documented. The subject child's mother would not allow DCDCFS to interview him and denied he visited the aunt's home.

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

Issue:
Failure to provide notice of report

Summary:
The record did not reflect the older cousin's father was provided written notice of the SCR report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
DCDCFS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
The older cousin's father was interviewed via telephone. He reported the older cousin primarily resided with him and visited the aunt. Despite this information, a visit to his home and face-to-face interview with him was not documented. In addition, the record did not reflect the father of the younger cousin was notified of the report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:

DCDCFS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

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

In 2008, the SM and MGM had an IND SCR report. The SM and MGM had an argument and fought over the SC by tugging on him. At case closure, a family friend was granted guardianship of the SC.

In 2009, the SM had an IND report regarding the SC. The SM was homeless, tested positive for cocaine and refused to attend a substance misuse evaluation. The case was opened for services.

In 2011, the SM had an UNF report that alleged the SM hit the SC with a belt.

In 2012, the SM had three UNF reports with allegations of IG, LMC, PD/AM and IF/C/S. The reports alleged concerns for supervision of the SC, inadequate provisions and medical care for the SC, the SM's marijuana misuse and the SC smelling of marijuana.

In 2012, there was an UNF report that alleged the SC's 21yo sibling held a lighter under his nose. It was determined the SC did not have a 21yo sibling.

In 2013, the MGM had an UNF report that alleged the MGM prostituted with the SC present.

In 2015, the SM had an UNF report that alleged concerns for the SM's marijuana misuse and discipline of the SC.

In 2016, the SM and MGM had an UNF report that alleged the SM was violent toward the SC and the SM and MGM did not follow recommended treatment for the SC's MH.

In 2017, the SM and MGM had an UNF report. The report was a court ordered investigation that alleged the SM and MGM fought in the presence of the SC.

In 2018, the SM had an UNF report, which alleged concerns of PD/AM.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

In 12/2009, the mother had a Preventive Services Case due to concerns for her homelessness and drug misuse. The mother obtained employment, got an apartment and produced a negative drug test. Once these tasks were accomplished, the mother declined to further work with preventive services and her case was closed in 2/2011.

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