Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-24-042

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

Issue Date: Feb 20, 2025

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Dutchess
Gender: Male
Date of Death: 09/12/2024
Initial Date OCFS Notified: 09/12/2024

Presenting Information

On 9/12/24, at about 11:00AM, the daycare provider put the subject in a crib to sleep. At about 2:11PM, the subject child was found unresponsive with vomit coming out of his mouth. The daycare provider performed CPR and called 911. EMS took over life-saving measures upon arrival and transported the subject child to the hospital. The subject child was pronounced deceased at 3:20PM. The daycare had no explanation for the subject child's death.

A second report was received on 9/18/24, which alleged the subject child fell on a playset on 9/8/24 and sustained a skull fracture while in the care of his parents. On 9/9/24, the subject child vomited, was unsteady, and fell; however, medical care was sought for an ear infection, acute respiratory infection, and a fever. On 9/11/24, the subject child was seen at an Urgent Care as he continued to vomit. Medical professionals were not notified of the fall during examinations despite the symptoms being consistent with a head injury.

Executive Summary

This report concerns the death of the 1-year-old male subject child that occurred on 9/12/24. The Dutchess County Department of Social Services (DCDSS) received two SCR reports regarding the fatality. The first report, received on 9/12/24, contained allegations of DOA/Fatality and Inadequate Guardianship against the daycare provider. The second report, received on 9/18/24, contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and father, and allegations of Lack of Medical Care against the mother. At the time of his death, the subject child resided with his mother and father.

On 9/12/24, the subject child was dropped off at daycare after several days of illness. The subject child did not present as his usual self; he cried intermittently and presented as fatigued. The subject child did not have his usual appetite but drank some milk before he was placed in his crib on his left side. The subject child fell asleep around 11:55AM. At approximately 1:55PM, daycare staff found him on his right side, unresponsive and cold, and appearing purple with foam coming out of his mouth. Daycare staff removed the subject child from his crib, placed him on the floor, and called 911. EMS responded, and the subject child was transported to the hospital where he was pronounced deceased at 3:20PM.

The mother and father were interviewed, and revealed the subject child hit his head on playground equipment on 9/8/24. Medical treatment was obtained; however, the caregivers did not disclose the subject child's head injury to the medical providers.

DCDSS interviewed the medical examiner who reported the cause of death was blunt force injury to the head, and the manner of death was undetermined. The medical examiner stated the explanation provided by the mother and father regarding the head injury the subject child sustained on the playground was not significant enough to have caused the linear skull fracture. The final autopsy report was pending the neuropathology report, which had not been completed as of this writing.

The case record contained thorough documentation of casework activities and numerous collateral contacts. Face-to-face meetings were held with several collateral contacts which provided DCDSS with an in-depth understanding of specific case information.

Offers of bereavement services and burial assistance were declined by the mother and father. The case was closed as there were no surviving siblings or identified service needs. Allegations against the daycare provider were unsubstantiated due to a lack of evidence that demonstrated the subject child was injured while at the facility. The mother and father were indicated for DOA/Fatality and Inadequate Guardianship due to the implausible explanations provided regarding how the subject child obtained the injuries that caused his death. Lack of Medical Care was unfounded against the mother due to evidence obtained regarding the mother seeking medical treatment at an Urgent Care and the pediatrician's office to address the lethargy and vomiting. The case was closed timely on 11/17/24.

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.

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:
The decision to close the case was appropriate. There were no surviving siblings and the parents declined referrals offered by DCDSS.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 09/12/2024 **Time of Death:** 03:20 PM

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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ 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	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)

LDSS Response

Upon receipt of the first SCR report, DCDSS initiated their investigation, coordinated efforts with LE, contacted the source, conducted a history check, and made diligent efforts to conduct a home visit.

On 9/13/24, DCDSS interviewed the DC provider who stated the SC was dropped off at around 8:20AM, and he did not have an appetite and slept more than usual. He appeared lethargic, wobbly, was crying, and vomited the milk and bread he ate. Staff called the SF who picked up the SC. The SC did not attend daycare for two days, returning on 9/12/24. He presented as tired, cranky, and cried intermittently. The SC had some milk before being placed in a crib on his left side at about 11:45AM; he fell asleep about ten minutes later. Around 1:55PM, the SC was found on his right side and appeared cold, purple, and had foam coming out of his mouth and ear. The SC was removed from his crib and placed on the floor while 911 was called. The DC provider denied the SC fell or hit his head at the facility.

The SM stated she took the SC to the park on 9/8/24, and the SC fell and hit his head on a play structure. The SM denied

hearing a big noise; however, the SC cried louder and longer than usual after the event. The SC was dropped off at DC on 9/9/24. The SF picked up the SC after he vomited, and he was taken to Urgent Care. The SC stayed home on 9/10/24 and 9/11/24. The SC wanted to sleep every 2 hours for 1-1.5 hours, did not have a good appetite, and cried at night. The SC was taken to the pediatrician on 9/11/24 to address vomiting and lack of appetite; however, the SM believed the SC was getting better. Other than DC staff, the SM denied any other caregivers for the SC. The SM stated she did not relate the SC's fatigue and vomiting to him hitting his head, and stated there were no immediate symptoms after the incident.

The SF corroborated the SM's account of the trip to the playground and the SC's injury. The following morning, the SF stated he took the SC to DC and received a call in the afternoon after the SC vomited. They took the SC to Urgent Care and were informed the SC had a virus. The SC woke up crying every 1-2 hours that night, and the SF held him and gave him water until he went back to sleep. The SC stayed home for two days with the SM, and the SF cared for him at night. The SC woke up every 2 hours crying loudly, which was not normal. On 9/11/24, the SC went to the doctor and the parents expressed concern regarding a possible foodborne illness. The SC was deemed "normal" after an assessment. On 9/12/14, the SC seemed better and returned to DC. The SF later received a PC from the SM informing him of an emergency with the SC. The SF denied the SC had any other caregiver while the SC was home, or any concerns with the DC.

The pediatrician reported the SC was seen in the office on 9/11/24, and the caregivers reported the SC consumed undercooked turkey. Information was provided to the family about vomiting and reintroducing foods. On the way out the door, the SM stated the SC had fallen on his bottom on 9/8/24. The pediatrician asked if he hit his head, and the SM stated, "no." The pediatrician stated the SC appeared as a normal 15-month-old during the appointment; however, the pediatrician noted the SF appeared nervous, the SM was quiet, and the injury could have been sustained at the DC.

An ER doctor stated life-saving measures were performed on the SC. While the doctor was holding the SC's head, he noticed an occipital hematoma near the back of his head, which he described as, "big and noticeable."

The ME reported the autopsy results showed the SC had a linear skull fracture on the left side above the ear. The SC had a bruise on his left cheek, two separate bruises on the back of his head that appeared a few days old, a scratch near his left eye and on his nose, a scabbed and healing abrasion present on his left side, hemorrhaging under the skin more on the left side of the head, and the brain was swollen. The ME stated the skull fracture could have happened between 9/8/24 and 9/11/24, and symptoms would have started within 24 hours of the injury. The ME expressed concern for the pattern of significant head trauma noted in the SC's records and the injuries found during autopsy, and stated the explanations given by the parents did not explain the injuries. The ME stated that if the caregivers had informed the doctors of a head injury when the SC was exhibiting lethargy and vomiting an X-ray or CAT scan may have been performed, and the injury may have been identified.

Offered services were declined by the family. No criminal charges were brought against the SM and SF at the time of this writing as LE was waiting on the neuropathology report. Allegations of DOA/Fatality and Inadequate Guardianship were substantiated against the SM and SF due to the implausible explanations provided for how the SC obtained the injuries that caused his death. The allegation of Lack of Medical Care against the mother was unfounded. DCDSS appropriately indicated and closed the case.

Official Manner and Cause of Death

Official Manner: Undetermined

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
069848 - Deceased Child, Male, 1 Year(s)	069849 - Mother, Female, 35 Year(s)	Lack of Medical Care	Unsubstantiated
069848 - Deceased Child, Male, 1 Year(s)	069849 - Mother, Female, 35 Year(s)	DOA / Fatality	Substantiated
069848 - Deceased Child, Male, 1 Year(s)	069849 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
069848 - Deceased Child, Male, 1 Year(s)	069850 - Father, Male, 36 Year(s)	DOA / Fatality	Substantiated
069848 - Deceased Child, Male, 1 Year(s)	069850 - Father, Male, 36 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

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 at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
Services were offered to the mother and father in response to the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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.

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