Child Fatality Report

Report Identification Number: RO-22-012

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

Issue Date: Oct 14, 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	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: 4 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 04/24/2022
Initial Date OCFS Notified: 04/27/2022

Presenting Information

Monroe County Department of Human Services (MCDHS) was notified by an additional information report made to the SCR, that the subject child was outside at a relative's home unsupervised, when he ran into the street, was hit by a car, and died. There was an open CPS investigation at the time of the fatality regarding unrelated concerns. MCDHS completed a 7065 Agency Reporting Form and notified the Rochester Regional Office within the required time frame.

Executive Summary

This fatality report concerns the death of a 4-year-old male child. MCDHS had an open case at the time of the death regarding concerns unrelated to the fatality. An autopsy was performed; however, the final report had not yet been issued at the time of this writing, and the results were pending. The preliminary cause of death was blunt force trauma.

At the time of the child's death, he resided with his mother and his 8-year-old sibling. The child's father did not reside in the home but did have regular contact with the child. The father of the sibling was unable to be located and did not have regular contact with her. MCDHS learned the mother had a history of untreated mental health concerns and a history of substance misuse. The mother was not in treatment at the time of the child's death. During the open investigation that began on 1/26/22, the mother had a safety plan in place that the children would reside with the grandmother until the mother was engaged and benefitting from her treatment. MCDHS reviewed the safety plan with the adults to ensure that everyone was in agreeance with the plan. The grandmother returned the children to the mother in March or April of 2022, because the grandmother believed the mother could adequately care for the children.

The investigation revealed that on the day of the fatal incident, the mother, child, and sibling were at a relative's home for a barbeque. It was unclear who was supposed to be supervising the child when he ran into the street and was struck by a car. Furthermore, it remained unknown who was supervising the sibling or how long the children had been unsupervised. EMS responded to the scene and performed resuscitation efforts while the child was transported to the hospital, where the child was pronounced deceased. The record did not reflect who called 911. MCDHS obtained the accident report from law enforcement, no tickets were issued, and no arrests were made.

MCDHS met with family members, but the uncle, who was present at the time of the fatal incident, was not interviewed. The mother made a plan for relative resources to care for the sibling. MCDHS offered the mother mental health and services for her substance misuse, and she declined. The mother agreed to grief counseling services for the sibling.

PIP Requirement
For citations identified in historical cases, MCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS will review the plan and revise as needed to address ongoing concerns.

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

Was the decision to close the case appropriate? N/A
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:
This was not an SCR-reported fatality; therefore, certain investigative activities were not required. MCDHS assessed the safety of the surviving sibling and determined her to be safe with the grandmother at the time of case closure.

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: 04/24/2022 **Time of Death:** 05:30 PM

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 05:08 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used 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	No Role	Male	4 Year(s)
Deceased Child's Household	Mother	No Role	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Other Household 1	Father	No Role	Male	25 Year(s)
Other Household 2	Other - Siblings Father	No Role	Male	31 Year(s)

LDSS Response

MCDHS was notified of the child's death by an additional information report made to the SCR. MCDHS notified the Rochester Regional Office and submitted the required 7065 Agency Reporting Form.

At the time of the fatality, the mother, child, and sibling were visiting the uncle's home for a barbeque. While the mother was inside the home, the child and sibling were outside. The mother reported the child was outside and was supposed to be supervised by the uncle. The child went into the road, was struck by a vehicle and passed away. Despite reasonable efforts made by MCDHS, they were unable to make contact with the uncle; therefore, he was not interviewed regarding the fatal incident or whether he was responsible for supervising the children, when the child was struck by a passing car. The record was unclear if the mother had spoken to the uncle regarding supervision, or if the uncle agreed to supervise the children. MCDHS met with the child's father, and he had no information regarding the fatal incident and the record did not reflect MCDHS asked about possible concerns regarding supervision.

The sibling reported being across the street with other family members on a trampoline when she heard the child whining and saw the child in the road. The sibling did not see the accident; however, reported seeing the child lying in the street with adults around him. The sibling was unable to identify who was responsible for supervising her and the child at the time of the accident. The record did not reflect attempts to interview other family members who were present at the time of the incident.

MCDHS interviewed the driver of the vehicle that had hit the child. The driver reported the child must have stepped out from in front of a parked vehicle as his vehicle drove by. When the driver hit the child, he did not see the child in the road, but saw adults standing in the yard. The driver thought he had hit a car mirror and went around the block to go back and see, that was when the driver saw people in the street screaming.

MDCHS contacted the mother's mental health providers who reported the mother had not actively engaged in treatment, missed several appointments, and was discharged from the program. The mother reached out after the fatality to re-engage with her mental health treatment, appointments were made, and the mother had not attended any of the appointments.

MCDHS consulted with their legal department regarding the case. The mother made a plan for relative resources to care for the sibling. The mother recognized she was struggling with her mental health and substance misuse after the death of the child. The mother had made the same plan in the past and had supports in place. At the time of case closure, the sibling was deemed safe in the care of the grandmother and a family friend and preventive services were put in place for the sibling.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality referred to 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
This was not an SCR-reported fatality; therefore, certain investigative activities were not required.

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?	☐	☐	☒	☐
Explain: The death was not an SCR-reported fatality; therefore, certain investigative activities were not required. MCDHS assessed the safety of the surviving sibling and determined her to be safe with the grandmother.				

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	☒	☐	☐	☐
Explain: MCDHS offered the mother services. The mother agreed to services for the sibling, but refused them for herself. The mother reported already having services in place.				

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: preventive services for the sibling							

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? Unable to Determine
Explain:
The mother initially declined services for the sibling; however, later changed her mind and agreed to services. The mother made herself unavailable to sign the necessary paperwork for the sibling to begin services. The record was not clear if services were started for the sibling after the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother was offered services but declined.

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?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
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)
01/26/2022	Deceased Child, Male, 4 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 4 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 28 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged the mother had undiagnosed mental health concerns and her behavior was unstable and unpredictable. The mother had blacked out and became angry. The mother was unable to adequately supervise the children. The mother was having a mental health breakdown and a Crisis Unit was on the way to help her.

Report Determination: Unfounded **Date of Determination:** 06/02/2022

Basis for Determination:
The mother acknowledged her ongoing mental health concerns and substance misuse struggles and planned for the children to be with the MGM while she engaged in treatment. On 4/24/22, while in the care of the mother, the SC was hit by a vehicle and died. Information obtained reported that this death was an accident, and no allegations were added. The mother left the SS with the MGM after the death of the SC. When the MGM felt the mother was mentally stable, she would slowly transition the SS back home to the mother. The SS was referred for mental health therapy. There was no evidence that the mother's mental health placed the SS in imminent danger.

OCFS Review Results:
MCDHS began their investigation in a timely manner and completed safety assessments on time. The record did not reflect that MCDHS checked history timely. Progress notes were not entered contemporaneously. Despite attempts, the uncle was not interviewed, and the mother's supervisory plan could not be confirmed.

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

Issue:
Review of CPS History

Summary:
A CPS history check was completed untimely on 2/1/22.

Legal Reference:
18 NYCRR 432.2(b)(3)(i)

Action:
Within 1 business day of a report, LDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, LDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
The record reflected that 9 out of 88 progress notes were not entered contemporaneously and were documented more than 30 days after the event date. These notes were from the beginning of the case on 1/26/22, regarding collateral contacts and face-to face home visit notes regarding 24-hour safety of the children.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/29/2021	Aunt/Uncle, Female, 17 Years	Mother, Female, 28 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Aunt/Uncle, Female, 17 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Mother, Female, 28 Years	Lack of Medical Care	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Mother, Female, 28 Years	Swelling / Dislocations / Sprains	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Grandparent, Female, 65 Years	Excessive Corporal Punishment	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Grandparent, Female, 65 Years	Inadequate Guardianship	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Grandparent, Female, 65 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Grandparent, Female, 65 Years	Lack of Medical Care	Unsubstantiated	
	Aunt/Uncle, Female, 17 Years	Grandparent, Female, 65 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
An SCR report received on 11/27/2021, alleged the MGM and adult sister (SC's mother) of the aunt beat the aunt with a broomstick. As a result, the aunt had sustained a bloody right index finger, numerous bruises to the right forearm and shin, a laceration above the left eye and pain to the back. The aunt was fearful of the MGM and her adult sister, and she refused to return home to the MGM's care. The MGM and the adult sister failed to ensure that the aunt received adequate medical treatment to address the injuries she sustained.

Report Determination: Unfounded | **Date of Determination:** 01/13/2022

Basis for Determination:
The MGM provided the aunt with a minimum degree of care and the MGM ensured the aunt was safe while she was out of the home. The MGM planned for the aunt to have a safe place to stay, provided her with clean clothes and her

medication. The aunt had no concerning marks or bruises. The MGM and the adult sister were advised not to use any type of physical force to retrieve items from the aunt.

OCFS Review Results:
Despite MCDHS documenting in their conclusion narrative the aunt did sustain bruises where they were alleged, they unfounded the report. There was no documentation MCDHS addressed concerns made in an additional information report. MCDHS missed multiple opportunities to ask the aunt where she was staying after she was no longer able to stay with her Godmother.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
Despite MCDHS observing and documenting the bruises which were alleged in the SCR report, they unsubstantiated the allegations and unfounded the report. The record did not reflect pertinent collaterals were contacted. The aunt was allegedly supposed to attend zoom therapy appointments. The record did not reflect MCDHS verified this was occurring, nor did they document that records were requested. The record did not reflect appropriate services were offered despite the MGM saying the aunt missed an intake appointment for her marijuana use. MCDHS obtained records from LE but did not document if MGM filed a missing persons report. On 12/8, MCDHSS spoke with the aunt twice by phone and neither time asked where she was staying or what her plan was, despite knowing she was no longer allowed to stay at her Godmother's after 12/7. MCDHS noted in their investigation conclusion the aunt was home safe; however, the record reflects the last face-to-face contact with the aunt was on 12/2.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
MCDHS will complete all casework as required and will document all casework activities.

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

In 2016, there was an SCR report received with allegations of inadequate guardianship against the mother regarding the sibling and the case was tracked FAR.

In 2018, the mother was indicated for inadequate guardianship, lack of medical care and lack of supervision regarding the sibling.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Foster Care Placement History

During on open CPS investigation, law enforcement discovered the sibling home alone. The sibling had a medical condition that required a higher level of care. The sibling was hospitalized. A safety plan was put into place with the grandmother. A week later, the mother and grandmother brought the sibling to a medical appointment and it was revealed that the grandmother did not have the sibling's lifesaving medical equipment with her. The mother and grandmother struggled in caring for the sibling's medical needs, which lead her to being admitted to the hospital. As a result, the sibling was placed in Foster Care on 8/30/18. The sibling was returned to the mother's care on 7/19/2019. The sibling was

removed as a result of the Neglect Petition that was filed on 9/5/18 regarding the sibling's medical neglect and the mother's inability to adequately care for the children. The subject child went into the care of his father and was returned to the mother's custody on 10/17/19 with an order of supervision in place.

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