Child Fatality Report

Report Identification Number: BU-23-016

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

Issue Date: Nov 13, 2023

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: 14 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 05/28/2023
Initial Date OCFS Notified: 05/29/2023

Presenting Information

On 5/29/23, an SCR report alleged the paternal grandmother was the sole caretaker of the 14-year-old subject child. The subject child was a diabetic and required insulin. The paternal grandmother failed to ensure that the subject child received her necessary medication. As a result, on 5/28/23, at approximately 4:00PM, the subject child was observed lying on the bathroom floor, vomiting. The subject child was not checked on again until approximately 11:00PM, seven hours later and at that time, the child was found on the bathroom floor, unresponsive. An unknown adult called 911. The police and emergency medical services responded to the home. EMS attempted life-saving measures, but the subject child was already deceased.

Executive Summary

On 5/29/23, Monroe County Department of Human Services (MCDHS) received an SCR report regarding the death of the 14-year-old female subject child that occurred on 5/28/23. Genesee County Department of Social Services (GCDSS) was assigned a secondary role. At the time of the death, the child was listed on an open CPS investigation regarding the child's diabetes not being managed appropriately by the mother and maternal grandmother. At the time of the death, the subject child was staying with the paternal grandmother. The fatality report contained allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care against the paternal grandmother. The father of the child was added to the report, although the father had been deceased since 10/29/20.

MCDHS and law enforcement collaborated investigative efforts and learned there was a long history of the child not checking her blood glucose levels or taking insulin to manage her diabetes. The day prior to the fatal incident the child was not feeling well, and the paternal grandmother was unable to verify what the child ate or if the child got any insulin that day. The day of the fatal incident the paternal grandmother said the child was still not feeling well and the child drank 3 bottles of ginger ale throughout the day and did not eat. The paternal grandmother said she gave the child her prescribed dose of insulin around 12:30PM and again around 4:00PM. Around 4:30PM the child was still not feeling well, and she vomited then laid on the bathroom floor. At about 6:00PM the paternal grandmother's aide went in the bathroom to check on the child and she was dry heaving, tried to kick him, and told the aide to leave her alone. The paternal grandmother told the child to check her blood glucose levels and the child said she was okay; however, the paternal grandmother did not ask the child what the levels were or administer any insulin to the child. Sometime between 10:00PM and 11:00PM, the aide went to check on the child in the bathroom and found the child unresponsive, cold, and blue. The paternal grandmother called 911 and first responders arrived at the home. EMS administered CPR, then noticed that rigor mortis had set in. The child was placed on a cardiac monitor and declared deceased at the scene.

MCDHS contacted the medical examiner's office, and an autopsy was performed; however, the final report was pending further testing at the time this report was written. MCDHS obtained a copy of the Death Confirmation and Summary Report from the medical examiner's office that listed the child's cause of death as Diabetic Ketoacidosis due to Diabetes mellitus type 1 and the manner of death was natural causes. Law enforcement investigated the incident, and no criminal charges were filed at the writing of this report; however, the criminal case remained open.

Due to the concerns regarding the open CPS investigation and the death of the child, MCDHS implemented a safety plan for the 2-year-old sibling. The sibling was placed with the mother's friend on 5/29/23. On 6/13/23, MCDHS returned the sibling to the mother's care. At the close of the investigation the sibling was assessed as safe with the mother.

MCDHS substantiated the allegations of DOA/Fatality, Inadequate Guardianship and Lack of Medical Care against the paternal grandmother regarding the child. MCDHS found sufficient evidence that the paternal grandmother failed to provide a minimal degree of care to the child. Although the paternal grandmother had an ample supply of medication for the child and was trained on how to provide for the child's diabetes management, the paternal grandmother did not ensure the child received her medication properly and did not take necessary steps to intervene and provide medical care when the child was exhibiting clear signs of Diabetic Ketoacidosis, which was the cause of her death. The paternal grandmother was offered bereavement services, and she declined. MCDHS offered the mother bereavement services and burial assistance, and she declined. The investigation was indicated and closed on 7/1/23.

PIP Requirement
MCDHS will submit a PIP to the Buffalo 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:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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:
MCDHS made an appropriate determination based on the evidence obtained throughout the investigation.

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:
Casework activity was commensurate with the case circumstances.

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: 05/28/2023 **Time of Death:** 11:55 PM

County where fatality incident occurred: Genesee
Was 911 or local emergency number called? Yes
Time of Call: 11:11 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: laying on the bathroom floor

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	Female	14 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	69 Year(s)
Other Household 1	Mother	No Role	Female	33 Year(s)

LDSS Response

On 5/29/23, MCDHS received a report regarding the death of the SC. MCDHS and GCDSS initiated the investigation within 24 hours and coordinated their efforts with law enforcement. The source of the report was contacted, a CPS history check for the family was completed, and the DA was informed of the fatality. MCDHS assessed the safety of the sibling and conducted an initial home visit on 5/29/23.

MCDHS and GCDSS interviewed all the adults regarding the events leading up to the SC's death. The BM and PGM had joint custody of the SC and the PGM had weekend visitation with the SC. The BM and MGM said the SC was taking her own blood glucose levels and would tell them what the numbers were. The BM and MGM reported that the SC would often refuse to take her blood glucose levels and insulin and, in the past, had to hold the SC down to give her an injection of insulin. The SC went to the PGM's home on 5/17/23, and she refused to return home. The SC was suspended from school on 5/17/23 after she refused to take her insulin at school and there was an incident with school staff. The BM

reported when the SC was sick, she always laid on the bathroom floor because it felt good to her, and the MGM would check the SC's ketones and administer insulin as needed until the SC felt better. The MGM picked up insulin for the SC and brought it to the PGM's home the weekend prior to and again the weekend of the fatal incident.

The PGM reported she was trained regarding the SC's diabetes management and was aware of the signs of Diabetic Ketoacidosis. While the SC stayed with the PGM, the PGM did not check the SC's blood glucose levels and only helped give the SC the insulin injection after the SC determined how much insulin she needed. The PGM and her aide could not confirm the SC had any insulin the day prior to her death. The PGM and the aide gave some conflicting information to LE when interviewed regarding when the aide checked on the SC while she was in the bathroom.

The SS was assessed at the time of the fatal incident and was placed with a friend of the BM on 5/29/23. The SS was returned to the BM on 6/13/23, with a safety plan in place regarding the BM's paramour. At the close of the investigation MCDHS assessed the SS as safe with the BM and the previous open investigation was ongoing. The SS was seen and appeared free of any visible marks or bruises.

MCDHS contacted multiple collateral sources such as school staff, medical staff, EMS, LE, and the paternal grandmother's aides. MCDHS learned the SC had missed several medical appointments regarding her diabetes maintenance and was last seen on 9/22/22. The SC should have been seen every three months for monitoring and insulin adjustment. Medical staff reported the SC had a long history of not accurately reporting her blood glucose levels and if the SC had missed her long-lasting insulin for a day or more, Diabetic Ketoacidosis could happen in a matter of hours. School staff confirmed the MGM picked up the SC's insulin during the week prior to the SC's death and that the SC had not been to school that week. School staff also confirmed the SC had behavioral issues and had tantrums when the SC needed to take her medication, and the SC often refused to take her insulin.

At the close of the investigation, there were no criminal charges brought against the PGM; however, the investigation remained open pending the final autopsy report. MCDHS found evidence to support the allegations in the report, and appropriately indicated and closed the investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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? Yes
Comments: The fatality was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065128 - Deceased Child, Female, 14 Yrs	065228 - Grandparent, Female, 69 Year(s)	DOA / Fatality	Substantiated
065128 - Deceased Child, Female, 14 Yrs	065228 - Grandparent, Female, 69 Year(s)	Inadequate Guardianship	Substantiated

065128 - Deceased Child, Female, 14 Yrs	065228 - Grandparent, Female, 69 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

Additional information:
All relevant collateral sources were interviewed.

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?	☒	☐	☐	☐

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	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐
Explain as necessary: There was no removal regarding the SS. The SS did not reside in the home of the PGM, she resided with the BM.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Bereavement services were offered to the BM, and she accepted but later declined. Burial assistance was offered to the BM, and she declined. Bereavement services were offered to the PGM, and she declined.

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? No
Explain:
Services were offered to the BM on behalf of the SS, and she declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services and burial assistance were offered to the BM, and she accepted but later declined. The PGM was offered grief counseling services, and she declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

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)
01/05/2023	Deceased Child, Female, 14 Years	Other Adult - Mother's paramour, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child,	Aunt/Uncle, Female, 31 Years	Inadequate Food /	Unsubstantiated	

Female, 14 Years		Clothing / Shelter	
Deceased Child, Female, 14 Years	Grandparent, Female, 53 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Female, 14 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Female, 14 Years	Other Adult - Mother's paramour, Male, 25 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 14 Years	Other Adult - Mother's paramour, Male, 25 Years	Lack of Medical Care	Unsubstantiated
Deceased Child, Female, 14 Years	Aunt/Uncle, Female, 31 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 14 Years	Aunt/Uncle, Female, 31 Years	Lack of Medical Care	Unsubstantiated
Deceased Child, Female, 14 Years	Grandparent, Female, 53 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 14 Years	Grandparent, Female, 53 Years	Lack of Medical Care	Substantiated
Deceased Child, Female, 14 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 14 Years	Mother, Female, 32 Years	Lack of Medical Care	Substantiated
Sibling, Female, 2 Years	Other Adult - Mother's paramour, Male, 25 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Years	Aunt/Uncle, Female, 31 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Years	Grandparent, Female, 53 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
Monroe County Department of Human Services (MCDHS) received two SCR reports dated 1/5/23 and 1/31/23, that alleged the SC was diagnosed with juvenile diabetes. The SC was required to take insulin shots daily to manage the diabetes. For the past two years, the SC's medical condition was not monitored, she missed numerous management appointments, refused to take her insulin, and presented with high blood sugar levels often. The BM, MGM, MA, and the mother's paramour (OA) were aware and failed to address the concerns. The SC was diagnosed with attention deficit hyperactivity disorder (ADHD) and was displaying oppositional defiant behaviors. The SC was unable to focus, refused to engage, and refused to comply with tasks. Services were recommended and referrals were given numerous times, and the adults failed to follow through. As a result, the SC's academics were negatively impacted. On a daily basis, the SC was visibly dirty, dressed in dirty clothes, had dirty hair, and body odor. On 1/16/23, the SM became physically aggressive towards the SC for an unknown reason. The BM hit the SC in the head hard enough that the SC experienced a headache after. The OA was verbally aggressive and threatened to be physically aggressive towards the SC. The OA was physically aggressive with the SS. The OA smacked the SS in the back for crying, locked her in her room, and forced her to stay there for hours. The BM, MGM, and MA were aware and failed to intervene.

Report Determination: Indicated | **Date of Determination:** 07/17/2023

Basis for Determination:
The allegations of IG and LMC against the BM and MGM were substantiated. The investigation revealed the SC was diagnosed with Diabetes Mellitus Type I. The BM and MGM failed to ensure the SC was in compliance with her diabetes

care. The SC missed required medical appointments, the SC's blood sugar levels were not being monitored and she was not receiving her insulin as prescribed. The SC passed away on 5/28/23, while in the care of her PGM. The allegations of IG, IF/C/S, and LMC, against the MA and the OA regarding the SC were unsubstantiated. MCDHS unsubstantiated the allegations of IG against the BM, MGM, MA, and the OA regarding the SS.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check, the 7-day Safety Assessment tool and notification letters were completed and provided within required time frames. The MGM refused to be interviewed and the family denied access to the home. The record did not reflect MCDHS consulted with their legal department regarding the case. The record did not reflect casework activity between 2/7/23- 4/12/23 and 4/13/23-5/22/23, despite ongoing concerns regarding the child's diabetes. The family declined preventive services and the case was indicated and closed on 7/17/23.

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

Issue:
Assessment as to need for Family Court Action
Summary:
There was a history of the BM and MGM not providing the SC with her insulin and they were inconsistent with ensuring the SC attended her required medical appointments to monitor and manage her diabetes. The BM and MGM were uncooperative with the department. School and medical staff reached out to MCDHS with concerns regarding the SC's uncontrolled diabetes and mental health. The record did not reflect MCDHS consulted with their legal department regarding further family court involvement.
Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)
Action:
MCDHS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
The pediatrician and the school reached out to MCDHS during the investigation with concerns regarding the SC's mental health and uncontrolled diabetes. The SC expressed she was depressed and did not want to be in the home because of the ongoing fighting between the adults. The SC also expressed concerns regarding the SS being hit by the OA. The record did not reflect MCDHS followed up regarding the concerns. There was no casework activity with the family from 2/7/23 to 4/12/23 and 4/13/23 to 5/22/23. This report was open and ongoing prior to the SC's death, and the SC subsequently passed away on 5/28/23.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
MCDHS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The OA resided in the home and was listed as an alleged subject on the SCR report. The record did not reflect MCDHS attempted to interview the OA regarding the report.
Legal Reference:
18 NYCRR 432.1 (o)

Action:
MCDHS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/05/2022	Deceased Child, Female, 13 Years	Mother, Female, 32 Years	Lack of Medical Care	Substantiated	Yes
	Deceased Child, Female, 13 Years	Grandparent, Female, 53 Years	Lack of Medical Care	Substantiated	

Report Summary:
Monroe County Department of Human Services (MCDHS) received an SCR report dated 7/5/22, that alleged the SC was diagnosed with Type 1 Diabetes and was prescribed insulin. The BM and the MGM failed to ensure the SC received her insulin as prescribed and/or needed and the child's blood sugar levels were high. Since 9/10/21, the BM and the MGM missed four medical appointments for the SC regarding her diabetes. The SS had an unknown role.

Report Determination: Indicated | **Date of Determination:** 10/10/2022

Basis for Determination:
The allegations of LMC against the BM and MGM were substantiated. The investigation revealed MCDHS interviewed the SC at school, and she denied not taking her glucose levels or insulin. The BM and MGM refused MCDHS access to the home and the SS. The MGM refused to be interviewed regarding the report. The BM acknowledged the SC missed an appointment but denied the SC had gone 4-5 months without being seen medically regarding her diabetes. MCDHS contacted the SC's endocrinologist and learned the SC had high blood sugar levels that indicated the SC was not taking her insulin. The SC missed 4 appointments from December 2021 through July 2022. The SC attended an appointment on 7/11/22 and her A1C was 14. The MGM reported the SC's glucose was high all the time. The BM and MGM failed to provide a minimum degree of care and placed the SC at imminent risk by failing to ensure that the SC received routine medical care pertaining to her Diabetes; monitoring the SC's Diabetes as required and administering medication as prescribed. The SM was informed that if a new report was made with the same and/ or similar allegations it could result in a petition being filed against her in family court.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check and the 7-day Safety Assessment were completed timely and written notice of the report was provided. The MGM refused to be interviewed and the family denied access to the home. MCDHS consulted with their legal department regarding the case. The record reflected no casework activity from 7/14/22- 9/12/22, although there were ongoing concerns regarding the SC's uncontrolled diabetes. The record reflected the SC was not seen until 9/15/22. The family declined preventive services.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The record did not reflect there was casework activity from 7/14/22- 9/12/22. The SC was not seen until 9/15/22 and there were ongoing concerns for the SC's uncontrolled diabetes. The SC's blood glucose levels were not monitored regularly, the SC's levels were high, and she had missed numerous medical appointments.

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

Action:

MCDHS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/10/2021	Deceased Child, Female, 13 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 13 Years	Grandparent, Female, 52 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 13 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 13 Years	Mother, Female, 31 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
Monroe County Department of Human Services (MCDHS) received an SCR report dated 11/10/21, that alleged the SC was diagnosed with Type 1 Diabetes. The SC was prescribed medication and insulin and the BM and MGM were not following through with the medical recommendations for the SC and did not give the SC insulin for 2 days. As a result of not getting the insulin the SC vomited, was nauseous and pale, had a headache, and a stomachache. The SC's blood glucose (BG) level was over 500, this was a high number for a child with Type 1 Diabetes. It was recommended the MGM take the SC to the emergency room, the MGM refused and took the SC home. If the SC's BG levels did not decrease, the SC was at risk of going into Diabetic Ketoacidosis. The SC displayed mental health concerns for some time and recommendations were made for the BM and MGM to seek treatment for the SC. The BM and MGM did not follow through with the recommendations and as a result, the SC refused to take her insulin, and refused to bathe on a regular basis. The SC appeared dirty and had a foul body odor. On 11/29/21, a subsequent report was received that alleged, the BM and the SC engaged in an argument that escalated and became physical. The SC kicked the BM and the BM hit the SC in the head. As a result of being hit, the SC left the home and was outside in the cold, in shorts, for an unknown amount of time. The SC did not sustain any visible injuries as a result of the SM's actions. The subsequent report was consolidated into the initial report.

Report Determination: Unfounded | **Date of Determination:** 12/22/2021

Basis for Determination:
The allegations of IG and LMC against the BM and MGM were unsubstantiated. The BM and MGM denied the allegations in the report. The investigation revealed the SC had behavioral issues and refused to take her insulin and check her BG levels. The BM and MGM were aware of the SC's behaviors and understood the importance of the SC taking the insulin and were well versed in the SC's diabetes. The SC reported the BM and MGM monitored her diabetes and knew what to do if her BG levels were high. The SC was not wearing her device that monitored her BG levels regularly and she reported she did not always take her insulin. The BM and MGM reported they checked the SC's urine for her ketone levels when the SC was sent home from school and there were no ketones in her urine; therefore, the SC was not in Diabetic Ketoacidosis. The MGM reported the SC had Diabetic Ketoacidosis in the past and the SC no longer showed symptoms when they arrived home. The MGM said she was in contact with the SC's endocrinologist the same day. MCDHS contacted the endocrinologist's office and staff confirmed the MGM did know what to look for regarding Diabetic Ketoacidosis, as the SC had gone into it previously. Staff confirmed the MGM called the day of the incident and made staff aware there were no ketones in the SC's urine and the BG levels went down. The BM denied hitting the SC in the head and reported she spanked the SC on the butt because the SC refused to clean her room. The SC left the house and stood out at the end of the driveway in shorts and socks. The BM watched the SC from the front door.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check and the 7-day Safety

Assessment were completed timely. The record did not reflect the father of the SS was identified or contacted. The record reflected there was no consultation done with the legal department regarding further family court action, despite supervisory instruction to do so. The BM and MGM were unable to control the SC's behaviors regarding the SC taking her insulin and monitoring her blood glucose levels. The allegations of IG and LMC were incorrectly unsubstantiated, as the SC's blood glucose numbers continued to be high, and the SC missed medical appointments that were needed to control her diabetes. The record did not reflect MCDHS followed up with preventive services, prior to the case closure, regarding the family being waitlisted for counseling services for the SC. The family was referred to community-based services for the SC's behaviors and the case was closed.

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

Issue:
Assessment as to need for Family Court Action

Summary:
There was a history of the BM and MGM not providing the SC with her insulin and they were inconsistent with ensuring the SC monitored her blood glucose levels and attended her required medical appointments to monitor and manage her diabetes. The record reflected in a supervisor note a legal consultation was needed regarding the family. The record did not reflect MCDHS consulted with their legal department regarding further family court involvement.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:
MCDHS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
Prior to the case closure on 12/22/21, MCDHS was made aware the SC's blood glucose levels were still high and the MGM reported the SC refused to take her insulin and requested services for the SC. The BM reported the SC missed her scheduled medical appointment on 12/13/21; however, it was rescheduled to 1/7/22. The BM and MGM were unable to control the SC's behaviors. The record did not reflect prior to case closure that MCDHS addressed the concerns with the BM or the SC. The record did not reflect MCDHS followed up with wait-listed services for the family. The case closing safety assessment reflected the BM and MGM were unable to control the SC's behaviors.

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

Action:
Prior to making a determination, MCDHS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The record did not reflect an identification of the SS's father or the SS's contact with the father. There were no efforts documented to locate, interview, or notify the father of the SCR report in writing.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
MCDHS 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.

Issue:

Appropriateness of allegation determination

Summary:

The allegations of IG and LMC were inappropriately unsubstantiated. The record reflected the BM and MGM allowed the SC to check her own blood glucose levels and she reported the numbers to the BM and MGM. It was unclear if the SC was checking her levels at home. The SC's blood glucose levels were consistently high throughout the investigation. The BM and MGM refused to monitor what the SC ate and acknowledged the SC needed services for her behaviors. There was a history of the SC not attending her required medical appointments and during the investigation the SC missed a medical appointment. The BM reported the SC did not wake up to go. As a result of the SC's blood glucose levels not being monitored, the SC's refusal to take her insulin, wear a blood glucose machine, and missed required medical appointments, the SC was placed at an imminent risk of harm.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

MCDHS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Rochester Regional Office if further guidance is needed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/24/2021	Deceased Child, Female, 12 Years	Grandparent, Female, 51 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 12 Years	Grandparent, Female, 51 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 12 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 12 Years	Mother, Female, 31 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

Monroe County Department of Human Services (MCDHS) received an SCR report dated 6/24/21, which alleged the SC had Type 1 Diabetes and required regular medical care and medication management. The BM and MGM were the primary caregivers, but were non-compliant with proper medical protocol for the SC. The SC snuck food in the middle of the night and was not getting her insulin. The SC was in charge of taking her own medication, and she was too young and immature to be in charge of her insulin. The year prior, the SC went into Diabetic Ketoacidosis (DKA) and was hospitalized. The SC was not engaged in academics and was failing as a result. On 5/24/21 and 5/25/21, the SC was vomiting excessively due to high blood glucose levels. The BM and MGM were aware that when this occurred, the SC needed immediate emergency medical care, and they did not bring her to the hospital.

Report Determination: Unfounded | **Date of Determination:** 11/03/2021

Basis for Determination:

The allegations of IG and LMC against the BM and MGM were unsubstantiated. The investigation revealed the SM and MGM did not take the SC to the hospital because they got her blood glucose levels under control. The SC was seen on 6/26/21, and MCDHS explained the importance of telling the BM and MGM if she had eaten food she was not supposed to. The SC was not seen again until 10/1/21 and her blood glucose levels at school were between 400-500. The SC reported she got in moods and did not want to take her insulin. The school reported concerns about the SC's behaviors and the SC had refused to take her insulin when her levels were high. Medical staff reported the SC's A1C improved and was 9.4 as of 9/10/21; however, was still high. MCDHS unfounded and closed the case as the SC's diabetes was being monitored and managed.

OCFS Review Results:

The MGM would not allow MCDHS into the home and safe sleep could not be observed for the then 7-month-old SS. The record did not reflect MCDHS consulted with their legal department to determine if family court was needed. The family was not seen from 6/26/21 until 10/1/21, when the SC was seen at school and a home visit was made. The record reflected MCDHS made two attempted home visits to two wrong addresses, despite an accurate address being documented in the case record. MCDHS referred the family to community-based services. Collateral contacts were made for the SS and there were no concerns regarding the SS.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
There was no ongoing assessment of safety between 6/26/21 and 10/1/21. MCDHS documented two attempted visits to incorrect addresses during that time, as the connections record was not updated to reflect the family's addresses obtained on 6/26/21.

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

Action:
Prior to making a determination, MCDHS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:
Assessment as to need for Family Court Action

Summary:
The record did not reflect a legal consultation was done regarding further family court involvement. There was a long history of the SC's diabetes not being managed. MCDHS was denied access to the home and safety could not be assessed for the then 7-month-old SS or the SC. There were ongoing concerns reported by school staff about the SC refusing to take her insulin when her levels were high. The BM and MGM were unable to control the SC's behaviors.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:
MCDHS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

[redacted]

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

An SCR report dated 3/5/19 was unfounded for the allegations of IG and IF/C/S against the PGM regarding the SC.

An SCR report dated 10/11/16 was unfounded for the allegations of IG against the PGM regarding an unrelated child.

An SCR report dated 7/16/15 was unfounded for the allegations of IF/C/S, IG, and PD/AM against the BM regarding the SC.

An SCR report dated 2/13/15 was unfounded for the allegations of XCP, IG, and L/B/W against the BM regarding the SC.

An SCR report dated 11/10/14 was indicated for the allegations of IG and LMC against the BM regarding the SC. The BM failed to exercise a minimal degree of care regarding the SC's diabetic monitoring. The BM did not follow the prescribed diet and failed to ensure the SC was administered her insulin as directed.

An SCR report dated 6/27/14 was unfounded for the allegations of IG against the PGM regarding the SC. The allegations of IG and LMC were unsubstantiated against the BM regarding the SC.

A FAR case dated 10/26/13 was opened regarding the BM, maternal aunt, and two unrelated home members not properly managing the SC's diet and insulin.

An SCR report dated 2/4/13 was unfounded for the allegations of IG against the PGM regarding the SC.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

A Preventive Services Case was opened on 4/6/15, to assist the mother and maternal grandmother with managing the SC's diabetes, diet, and behaviors. The case was closed on 5/13/15, due to no response from the BM to meet for weekly sessions. Goals were not achieved and were not worked on due to no contact after the first session.

A Preventive Services Case was opened on 1/15/13, to assist the mother with managing the SC's Type 1 Diabetes and diet. The mother was not compliant with the SC's routine medical care or follow up when the SC's blood glucose levels were high. The FSS was closed on 2/28/13, and goals were achieved. The mother brought the SC to medical appointments and the mother learned the SC's diabetes management.

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