Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-22-023

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

Issue Date: Jan 20, 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 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: 14 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 08/02/2022
Initial Date OCFS Notified: 08/03/2022

Presenting Information

On 8/1/22, Monroe County Department of Human Services (MCDHS) received a report from the SCR alleging the 14-year-old child was on life support after he fell out of the window of a moving vehicle on 7/31/22. On 8/2/22, MCDHS was notified of the child's passing. At the time the fatal incident was reported to the SCR, there was an open CPS investigation that began on 7/20/22. The open investigation alleged the parents were unable to control the child's behavior. MCDHS completed a 7065 Agency Reporting Form and notified the Rochester Regional Office timely.

Executive Summary

This fatality report concerns the death of a 14-year-old male child. At the time of the child's death, MCDHS had been investigating the fatal incident which was reported to the SCR on 8/1/22. At the time the fatal incident, the family had an open CPS investigation that began on 7/20/22 with concerns the child would leave the home and stay out in the community throughout the night. Additionally, the child had a history of using drugs and in May of 2022, the child required medical attention and was hospitalized. Although the vehicle accident that led to the child's death was reported to the SCR, it was unknown if the child had a history of drug use or out of control behavior at the time of the death, and a report was not registered for that reason. At the time of the child's death, he resided with his father, adult sibling, and nephew. The child's mother did not reside in the home but did have regular contact with the child. Following the child's death, MCDHS assessed the safety of the 9-month-old nephew that resided in the home. The home was assessed, and the nephew was deemed safe in the care of his family.

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 complications of blunt force injuries of the head, and the manner of death was an accident.

The father reported that due to his brain injury, he was unable to control the child's behaviors. Prior to the fatality, the mother and child were engaged with community-based services to address the child's drug use and staying out late at night. The adult sibling was interviewed and reported the parents tried to control the child's behavior, but the child would not listen and did what he wanted.

Law enforcement provided information that the child was riding in a vehicle on 7/31/22 around 4:00AM, and fell out of the vehicle after the driver made a turn. The child hit his head when he fell out of the vehicle, sustained multiple brain injuries, and went into cardiac arrest. An unknown person called 911. The child was transported to the hospital and placed on life support. MCDHS learned the child had tested positive for drugs and had no brain activity. The child was pronounced deceased on 8/2/22.

MCDHS offered the family bereavement services and they declined.

PIP Requirement
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

Explain:
Safety Assessments were not required because this was not an SCR reported fatality.

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:
Casework activity was commensurate with 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: 08/02/2022 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 07/31/2022
Time of fatal incident, if different than time of death: 04:00 AM

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
Child's activity at time of incident:
☐ Sleeping ☐ Working ☒ Driving / Vehicle occupant

☐ Playing ☐ Eating ☐ Unknown
☐ Other

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Adult Sibling	No Role	Female	23 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	14 Year(s)
Deceased Child's Household	Father	No Role	Male	45 Year(s)
Deceased Child's Household	Other Child - nephew	No Role	Male	9 Month(s)
Other Household 1	Mother	No Role	Female	48 Year(s)

LDSS Response

On 8/1/22, MCDHS received an SCR report regarding the fatal incident. On 8/2/22, MCDHS received an additional information report generated by the SCR that noted the child's death. MCDHS notified the Rochester Regional Office and submitted the required 7065 Agency Reporting Form.

At the time of the child's death, MCDHS had an open CPS investigation dated 7/20/22, that alleged the parents and adult sibling were unable to control the child's risk-taking behaviors and drug use. The child was observed slurring his words and appeared to be impaired. EMS was called and the child was sent to the hospital regarding possible drug misuse on 7/20/22.

MCDHS met with the family at the hospital. The father reported he tried to discipline the child but was unsuccessful and the child continued to do whatever he wanted. The father reported having a brain injury and due to his medical conditions, he was unable to control the child's behaviors. The adult sibling had no concerns for the father's care of the child; however, the child did not listen to the parents and continued to stay out late and use drugs. Despite reasonable efforts made by MCDHS, they were unable to interview the mother regarding the fatality. The record did not reflect if the parents or the adult sibling were aware the child was not home and was out in the community when the fatal incident occurred around 4:00AM.

Law enforcement records from 7/31/22 revealed the child was hanging out the window of the vehicle and after the driver made a turn and the child fell out of the vehicle. Law enforcement found the child in the road with injuries to his head and he was unconscious. Emergency medical services arrived at the scene and began to perform lifesaving measures and transported the child to the hospital. The child suffered a brain injury and was placed on life support.

MCDHS contacted the community-based agency the family was working with regarding the child's drug use and staying out late at night. The family had been engaged with the agency since June 2022 and three sessions were completed.

MCDHS offered the family bereavement services and they declined.

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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
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: This was not an SCR reported fatality; therefore, Safety Assessments were not required. MCDHS assessed the safety of the nephew, and determined him to be safe with the adult sibling.				

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: This was not an SCR reported fatality; therefore, the Risk Assessment Profile was not required.				

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	☐	☐	☐	☐	☐	☒	☐

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? N/A
Explain:
Due to the nephew's age he was not referred for services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS offered the family bereavement services and the family 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? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

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

Report					
07/20/2022	Deceased Child, Male, 14 Years	Mother, Female, 48 Years	Childs Drug / Alcohol Use	Unsubstantiated	No
	Deceased Child, Male, 14 Years	Mother, Female, 48 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 14 Years	Mother, Female, 48 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 14 Years	Father, Male, 45 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Deceased Child, Male, 14 Years	Father, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 14 Years	Father, Male, 45 Years	Internal Injuries	Unsubstantiated	
	Deceased Child, Male, 14 Years	Father, Male, 45 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 14 Years	Adult Sibling, Female, 23 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Deceased Child, Male, 14 Years	Adult Sibling, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 14 Years	Adult Sibling, Female, 23 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged the mother, father, and adult sibling were unable to control the risk-taking behaviors of the child. The child left the home when he wanted and stayed out in the community until 4:00AM. When unsupervised, the child was using drugs and alcohol on a regular basis. The adults were aware but failed to act. On 7/20/22, the child overdosed on an unknown illicit substance and needed emergency medical attention. The parents minimized the concerns. On 7/31/22, the child was riding in a car with friends around 4:00AM. The child fell out of the car, sustained a brain injury, and was placed on life support.

Report Determination: Unfounded | **Date of Determination:** 11/02/2022

Basis for Determination:
MCDHS met with the family members and the child admitted to using drugs and alcohol occasionally. The father had a brain injury that prohibited him from being able to intervene to control the child's behaviors. The child and mother were engaged with community-based services prior to the child's death regarding the child's drug use and staying out late, no parenting concerns were reported. MCDHS found no evidence to show the adults' actions placed the child at imminent risk of harm. The adults' were addressing the child's behaviors prior to his death.

OCFS Review Results:
MCDHS initiated the report in a timely manner and made home visits. MCDHS made efforts to interview the mother but were unsuccessful. The record reflected the nephew was assessed safe with his family and there were no concerns for the nephew's care. MCDHS spoke with collateral contacts and the family was engaged with community based services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/27/2021	Other Child - nephew, Male, 2 Months	Adult Sibling, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes

	Other Child - nephew, Male, 2 Months	Adult Sibling, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged on 12/27/21, the adult sibling was driving a vehicle with her friend and the nephew, then 2-months-old. Both the adult sibling and her friend were impaired on unknown substances. The adult sibling stayed in a hotel room with the nephew and friend. The adults had sexual relations while the nephew was in the bed next to them. The adult sibling had no crib for the nephew; therefore, the nephew slept in the bed with the adults.

Report Determination: Unfounded | **Date of Determination:** 03/02/2022

Basis for Determination:
MCDHS found there was not enough credible evidence to substantiate the allegations of IG and PD/AM against the adult sibling regarding the nephew. MCDHS found no credible evidence to suggest the adult sibling was co-sleeping with the nephew or had sexual relations with someone while the nephew was in the bed. Safe sleep recommendations were reviewed and observed for the nephew. There was no indication the adult sibling was misusing drugs. The nephew was safe in the care of the adult sibling and the case was unfounded and closed.

OCFS Review Results:
MCDHS checked history within the required timeframe, made home visits and assessed the safety of the nephew and the home. The record reflected collateral contacts were made and progress notes were entered in a timely manner. The record did not reflect the nephew's father was provided with written notice of the SCR report.

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

Issue:
Failure to provide notice of report

Summary:
The record did not reflect the nephew's father was provided with written notice of the SCR report

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

Action:
MCDHS will make diligent efforts to contact absent parent(s) of children named in a report and will send a Notice of Existence letter if contact information is available within seven days of receipt of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/28/2021	Other Child - nephew, Male, 4 Days	Other Adult - father of the other child, Male, 25 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
An SCR report alleged on 10/28/21, the nephew's father assaulted the adult sibling while she was holding the then 4-day-old nephew. The nephew did not sustain any injuries but was at risk of harm because of the nephew's father abusive actions.

Report Determination: Indicated | **Date of Determination:** 01/07/2022

Basis for Determination:
MCDHS learned the nephew's father assaulted the adult sibling while she was holding the nephew. The nephew's father was escorted out of the adult siblings hospital room and the police were called. The nephew's father was unable to be located regarding this report. The allegation of Inadequate Guardianship was substantiated against the nephew's father, he placed the nephew at risk of harm when he physically assaulted the adult sibling while she was holding him.

OCFS Review Results:
MCDHS interviewed the adult sibling and conducted a home visit. The record did not reflect a CPS history check was completed. The nephew was seen and safe sleep was observed at the adult siblings home. Safety Assessments were

completed on time and collateral contacts were made. The record did not reflect diligent efforts to locate the nephew's father regarding the investigation.

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

Issue:
Review of CPS History
Summary:
The record did not reflect a CPS history check was completed.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
MCDHS will review all prior CPS history within regulatory required timeframes.

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:
The record did not reflect that MCDHS made diligent efforts to locate the nephew's father, who was the subject of the report. MCDHS did not document an attempt was made to conduct a face-to-face interview with the nephew's father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/27/2021	Deceased Child, Male, 13 Years	Father, Male, 44 Years	Childs Drug / Alcohol Use	Unsubstantiated	Yes
	Deceased Child, Male, 13 Years	Father, Male, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 13 Years	Adult Sibling, Female, 21 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Deceased Child, Male, 13 Years	Adult Sibling, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 44 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the mother and the adult sibling purchased marijuana for the then 13-year-old subject child. The father was aware and allowed the subject child to use the marijuana to get high.

Report Determination: Unfounded | **Date of Determination:** 07/22/2021

Basis for Determination:
The mother, adult sibling and father denied the adults bought or allowed the child to use drugs. The child reported obtaining marijuana from a friend. The family reported they had never observed the child under the influence of any drugs and were consistent with the child using marijuana one time only. MCDHS offered the family preventive services

and they declined. MCDHS made collateral contacts and there were no concerns for the family. The case was unfounded and closed due to a lack of credible evidence.

OCFS Review Results:
MCDHS made home visits and interviewed all the family members face-to-face. MCDHS mailed notification letters and submitted Safety Assessments in a timely manner. A CPS history check was completed untimely.

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

Issue:
Review of CPS History

Summary:
The record did not reflect a review of history was done timely.

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

Action:
Within one business day, MCDHS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/21/2020	Deceased Child, Male, 12 Years	Father, Male, 43 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 12 Years	Father, Male, 43 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:
An SCR report alleged on 4/20/20, the father punched the subject child in the legs for an unknown reason and the subject child sustained bruising to his legs. The subject child had diagnosed mental health disorders and it was unknown if the subject child was compliant with his mental heath treatment. On 4/21/20, the subject child argued with and pulled a knife on the father, and knocked the father's motorcycle over. The father responded by getting into a physical altercation with the subject child. The role of the mother was unknown.

Report Determination: Indicated | **Date of Determination:** 06/11/2020

Basis for Determination:
The investigation revealed the subject child was upset because he could not have a bonfire or ride the 4-wheeler and began kicking the father. The father reported he was punching away the subject child's legs, which caused the bruises to the subject child's legs. Some credible evidence was found to substantiate the allegations of IG and L/B/W against the father regarding the subject child. The mother and the subject child engaged with services and the case was indicated and closed.

OCFS Review Results:
Home visits were conducted, and all family members were seen and interviewed. Safety Assessments and the RAP were completed timely and accurately. Relevant collaterals were contacted, including the pediatrician. The family was referred for services and the father refused to participate. Services continued for the subject child and the mother.

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

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

11/22/2019	Deceased Child, Male, 12 Years	Father, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 12 Years	Father, Male, 42 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
An SCR report alleged on 11/21/19, the father was angry with the subject child because he was throwing a football and accidentally hit the mother. The father slapped the subject child in the right eye. The subject child sustained swelling to his eye and was unable to open the eye. The mother had an unknown role.

Report Determination: Unfounded | **Date of Determination:** 03/24/2020

Basis for Determination:
The investigation revealed the father lightly hit the child in the eye and there was no bruise the next day. The child was not in pain and his eye was not affected. Due to a lack of credible evidence, the allegations of Inadequate Guardianship and Swelling, Dislocations, and Sprains were unsubstantiated, and the case was unfounded and closed.

OCFS Review Results:
Home visits were conducted, and all family members were seen and interviewed. Safety Assessments and the RAP were completed timely and accurately. Relevant collaterals were contacted, including the school and the pediatrician. The record did not reflect that NOE's were sent to the required adults in the report.

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

Issue:
Failure to provide notice of report

Summary:
The record did not reflect that NOE's were sent to the required adults in the report.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/09/2019	Other - unrelated child, Female, 11 Years	Mother, Female, 46 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other - unrelated child, Female, 11 Years	Other - unrelated adult, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Other - unrelated child, Female, 11 Years	Other - unrelated adult, Male, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged several times a week, the unrelated adult male and the mother misused unknown drugs in the presence of the unrelated child and left the drugs accessible to the unrelated child. When the unrelated adult male was under the influence of the unknown drugs, he became verbally and physically aggressive toward the mother in the presence of the unrelated child.

Report Determination: Unfounded | **Date of Determination:** 03/19/2020

Basis for Determination:
MCDHS made home visits and the mother and unrelated adult male had not appeared to be under the influence of any

substance. There was no evidence of drugs or paraphernalia observed in the home. The mother, other adult and other child denied anyone in the home abused drugs or alcohol or that the other adult was physically aggressive. Collaterals were contacted and there were no concerns for the unrelated child. Due to a lack of credible evidence, the allegations of IG and PD/AM were unsubstantiated, and the case was unfounded and closed.

OCFS Review Results:
MCDHS entered case notes in a timely manner and conducted face-to-face interviews with all case members. The record reflected the NOE letters and the 7-day safety assessment were not completed in the required time frame.

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

Issue:
Failure to provide notice of report
Summary:
Notice of Existence letters were provided untimely on 11/1/19.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
MCDHS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-Day Safety Assessment was not completed on time.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
MCDHS will document and approve all safety assessments within the required time frame.

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

In 2003, the mother was named as a subject in an indicated investigation with allegations of IG and LMC regarding the adult sibling.

From 2013-2018, the mother and father we named in 6 FAR cases with allegations of IG, L/B/W, XCP, and PD/AM regarding the subject child.

The father was named in an unfounded case in March 2019, with allegations of IG, L/B/W regarding the subject child.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Preventive Services History

The family was recommended for preventive services from 6/18/20-8/7/20, regarding the subject child's behaviors. The mother and subject child participated in two sessions; the father declined to participate at all. The case closed unsuccessfully on 8/7/2020, due to lack of engagement. The family stopped engaging and did not respond to therapist's outreach.

A Preventive Services case was open from 7/11/13-11/1/13, to assist the mother with finding her own housing and parenting education regarding the subject child's behaviors.

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